Advancing School Mental Health in Montana: A Report on Changes to Administrative Rules for Comprehensive School and Community Treatment

Erin M. Butts, MSW

Prepared for: State of Montana Office of Public Instruction
and Department of Public Health and Human Services
Helena, Montana
3 December 2010

Distributed by:
Montana
Office of Public Instruction
Denise Juneau, State Superintendent
opi.mt.gov

Table of Contents

Table of Figures

Section I: Executive Summary

Introduction:

Comprehensive School and Community Treatment (CSCT) exists as an "intense service designed for youth who are in immediate danger of out-of-home placement and/or exclusion from school or community," providing a "comprehensive, planned course of outpatient treatment…to a child with a serious emotional disturbance (SED)" (Montana Department of Public Health and Human Services, 2003, p. 2.6).

Early 2010, the Department of Public Health and Human Services (DPHHS) and the Montana Office of Public Instruction (OPI) agreed to collaborate in an effort to enhance mental health services to the children and families of Montana public schools. One result of this collaboration is this report, meant to guide changes to Administrative Rules for CSCT.

From academic year (AY) 2008-09 to AY 2010-11, the total number of CSCT contracts increased by 21, an 11 percent rate of change. This increasing trend of 191 to 212 providers in 84 school districts underscores the need for research-based decisions on the part of the state (Montana Office of Public Instruction, 2010).

Although the structure of CSCT may change as a result of Administrative Rules revision, it is important to acknowledge and recognize areas of strength already within CSCT. It is equally important to analyze the limitations in CSCT implementation, which include gaps in: training; program development, assessments and evaluations; and financing mental health services in schools.

This report seeks to highlight the disparities in Montana's CSCT program in light of national trends and best-practices implemented in research-based approaches elsewhere.

Methods

Researchers Weist and Paternite (2006) offer definitions of School Mental Health (SMH) that address the limitations of traditional SMH and consider more comprehensive and integrated services that expand from individual students to the families, schools, and communities of those students.

As an alternative to traditional SMH treatment, the Center for School Mental Health (2009) proposes Quality Assessment and Improvement (QAI), a framework in keeping with the comprehensive, research-based definitions of SMH, as proposed by Weist and Paternite (2006). Research-based definitions of SMH, QAI frameworks, and research-based principles for Expanded School Mental Health (ESMH) – a more comprehensive approach to SMH – all engender their own complications, but when implemented together, approach inclusive systems change.

Other approaches to SMH include the Positive Behavioral Intervention and Supports (PBIS) model, which is gaining recognition as an effective means of integrating mental health within school systems. Montana's PBIS adaptation is called Montana's Behavioral Initiative (MBI), modeled after the national Positive Behavioral Intervention and Supports (PBIS).

In addition, the National Assembly on School-Based Health Care (NASBHC), a technical assistance center in Washington, D.C., employs several principles that correlate with the principles of Expanded School Mental Health as evidence for their proposal of School-Based Health Centers (SBHC), which show such successful results as partners in overall SMH, as evidenced in this report.

The author proposes and researches seven pillars for ESMH, which serve as tenets to comprehensive SMH change. These pillars include: *prevention and early intervention*; *family-school-community*; *interdisciplinary collaboration*; *supervision*; *outcomes and evaluation*; *evidence-based practices*; *promotion of mental health*; *youth leadership opportunities*; and *training*, providing specific recommendations for each.

Recommendations

Several recommendations are formulated in this report: 1) a group specific to the seven pillars of Expanded School Mental Health; 2) a group specific to the process of Administrative Rule changes and; 3) a group specific to funding of CSCT programs. No one recommendation in this report is meant to be exclusive of another; rather, each is made with the intent of inclusive changes to Administrative Rules. More so, the recommendations of this report beg their own discussion among stakeholders and underscore the need for positive collaboration in the Administrative Rule-change process.

Recommendations with respect to Pillars of ESMH

Prevention and Early Intervention: Language including "children or youth at risk" may be more comprehensive than the current Administrative Rule language regarding students with disabilities, those diagnosed with a "Serious Emotional Disorder." Revise CSCT Administrative Rules to include the language of "prevention" and "early intervention" AND revise 37.87.303 to expand the definition of Serious Emotional Disturbance.

Family-School-Community: It could be assumed that by the nature of a CSCT therapist working within a school environment, individual and group therapies are the primary ways CSCT teams implement services in Montana. It could also be assumed that CSCT providers can only offer and bill for services within the schools themselves, pursuant to their ability to bill Medicaid. Consider researching CSCT teams who already implement the ethic of offering services off school campuses, despite non-billable constraints. If Medicaid is the only and/or primary funding avenue for CSCT services, and if this is proven through an evaluation of CSCT services in schools across Montana, Administrative Rules could also add language to adjust organization and school accountability toward the finances of CSCT teams to ensure an increase in family and community involvement.

Interdisciplinary Collaboration: As written, Administrative Rules do not effectively consider interdisciplinary collaboration, nor do they adequately recognize mental health professionals already in place within schools systems. Administrative Rules AND school/CSCT provider contracts could add language to integrate interdisciplinary collaboration.

Supervision: Administrative Rules could include language that would support supervision needs of employees such as discussing cases, doing site visits, and allowing for the flexibility of peer-to-peer supervision. If supervision time is limited to administrative responsibilities such as billing and paperwork, the chance of CSCT workers feeling supported may decrease, leading to employee dissatisfaction and higher turnover. Montana OPI and DPHHS could research CSCT supervision through qualitative and quantitative research methodologies by means of surveys and CSCT focus groups.

Outcomes and Evaluation: Administrative Rules could be strengthened through the implementation of a statewide evaluation of CSCT every two to three years. This

evaluation could happen through both quantitative and qualitative research methodologies.

Evidenced-Based Practices: Administrative Rules could include language that broadens how schools and CSCT teams consider working with evidence-based interventions through training structures. Due to the precautions offered by Wandersman (2003), the implementation of Evidence-Based Practices through revised CSCT Administrative Rules should take place over a long-term period, include consistent training and oversight, and a thorough review of costs associated with implementation.

Youth Leadership Opportunities: Administrative Rules could include the language of "promotion of mental health" as a means of integrating alternative supports to CSCT efforts. Since the intent of the Administrative Rules is to guide the work of helping youth and families, adding language to support "youth engagement" could also increase the efficacy of CSCT teams.

Training: Administrative Rules could hold CSCT providers more accountable by separating the type of trainings that the "Therapist" and "Behavioral Aide" positions receive. Training requirements in the current Administrative Rules do not support that a licensed Therapist should have professional training requirements that are different from a Behavioral Aide position, nor is ongoing skill-development for the licensed Therapist stipulated.

Recommendations with respect to the Process of Administrative Rule Change

Include Stakeholders: Involve multiple stakeholders in CSCT Administrative Rule change process. It is recommended that the Department of Public Health and Human Services and the Office of Public Instruction include representation from the spectrum of stakeholders from youth to outpatient therapists.

*Continue with Evaluation and Assessment of CSCT***:** Conduct a thorough evaluation of CSCT by implementing a Quality Assessment and Improvement analysis. A continued thorough evaluation of CSCT would help Montana perceive gaps in current Administrative Rules and offer an opportunity to include stakeholders. Such an evaluation should be done through quantitative and qualitative research methodologies and could incorporate Community-University (C-U) partnerships, the support of national technical assistance centers, and seek to support the recommendations of ESMH found in this report.

Increase the Use of Technology: Increase the use of technology for therapeutic services, professional development, and statewide collaboration.

Work Collectively: All nine CSCT providers begin working collectively to come up with a shared agenda and shared goals. Andis, et al. (2002), argue the importance of professional organization, policy leaders, and families to develop a shared agenda. All nine CSCT providers could collaboratively discuss a vision of CSCT programs.

Recommendations with respect to Funding for CSCT

Implement Additional Funding Sources: Comprehensive School and Community Treatment providers, schools, and communities could implement additional funding opportunities outside of Medicaid to broaden School Mental Health. If a percentage of CSCT budgets were mandated to be funded from additional sources other than Medicaid, doors could open for the availability of CSCT teams to work with a child or youth from any financial background and, thereby, any youth in need.

Apply for Grant Funding: Reapply for the Integration of Schools and Mental Health Systems Grant. Nationally, many states have been able to forward SMH through the support and funding of the Integration of Schools and Mental Health Systems Grant, the average award of which for 2009 was $347,800 (U.S. Department of Education, 2010).

Section II: Acknowledgements

The author, the Montana Department of Public Health and Human Services, and Montana Office of Public Instruction would like to thank the tremendous amount of support from individuals across the United States and acknowledge the following individuals for their willingness to respond to our questions and research process: Howard Adleman, Ph.D., UCLA School Mental Health Project/Center for Mental Health in Schools; Linda Anderson, MPH, West Virginia Health Technical Assistance and Evaluation Center; Marc Atkins, Ph.D., Professor of Psychiatry and Psychology, University of Illinois at Chicago; Jessica Aufrichtig, MSW, Behavioral Health Coordinator, New Mexico Public Education Department; Lisa Betz, LCSW, LCPC, Mental Health and Schools Coordinator, Department of Mental Health – Child and Adolescent Service System; Michele Carmichael, Principal Consultant, Schools and Mental Health Supports, Illinois State Board of Education; Jim Caringi, Ph.D., Masters in Social Work Program Director, Assistant Professor, University of Montana – Missoula; Nic Dibble, LSSW, CISW, Education Consultant, School Social Work Services, Wisconsin Department of Public Education; Lucille Eber, Ed.D, Statewide Director, Illinois PBIS Network; Sharon Hoover Stephan, Ph.D., Assistant Professor, Center for School Mental Health, University of Maryland; Laura Hurwitz, LCSW, School Mental Health, National Assembly on School-Based Health Care, Washington, D.C.; Lauren Kazee, LMSW, Mental Health Consultant, Michigan Department of Education/Michigan Department of Community Health; Vicki Mohnacky, West Virginia Department of Education, Office of Special Programs, Extended and Early Learning; Joyce Sebian, MS Ed., Center for Child and Human Development at Georgetown University, National TA Center for Children's Mental Health, Washington, D.C.; Julie Owens, Ph.D., Associate Professor, Center for Intervention Research in Schools, Ohio University; Kelly Stern, School-Based Behavioral Health Program, Honolulu, HI; Linda Taylor, Ph.D., Co-Director, Center for Mental Health in Schools, UCLA Department of Psychology; Rick Van Den Pol, Ph.D., Director and Principal Investigator, Institute for Educational Research and Service, University of Montana – Missoula. Mark Weist, Ph.D., Department of Psychology, University of South Carolina. Without the support of these individuals, this report would not be possible.

The author would like to especially acknowledge the support of: Bonnie Adee, Montana Department of Public Health and Human Services; Sara Casey, Montana Office of Public Instruction; Bob Runkel, Montana Department of Public Health and Human Services; and Rick Van Den Pol, Institute for Educational Research and Service.

It is also important to acknowledge the numerous CSCT providers, employees, and administrators in Montana who have been generous with their knowledge and expertise.

In addition, thanks to the many Montana public school administrators and teachers who have availed their knowledge from an educational perspective.

Finally, thanks to the families and youth of Montana who have offered their important stories and meaningful experience, reminding us to do the best work possible.

Section III: Introduction

School Mental Health (SMH) is one of the fastest growing professional fields for mental health workers and public school systems. This is the case for Montana's School Mental Health program, called Comprehensive School and Community Treatment (CSCT). Due to the vast increase in CSCT contracts over recent years, Montana has tasked itself to revise current CSCT Administrative Rules, using research and evidence-based practices to guide change. Early 2010, the Department of Public Health and Human Services (DPHHS) and the Office of Public Instruction (OPI) agreed to collaborate in an effort to enhance mental health services to the children and families of Montana public schools. One result of this collaboration is this report, meant to guide the changes to Administrative Rules for CSCT.

As a state, Montana is unique. Its geographic size and its demographic makeup comprise two challenges to advancing SMH, owing to the rural composition of many public schools that exist across sizeable distances. When considering CSCT Administrative Rules, it is important to note the following characteristics as well: Montana's racial composition is 90.6 percent white, 6.2 percent American Indian, 2.0 percent Hispanic, 0.6 percent Asian, 0.3 percent Black, and 0.6 percent other. However, school demographics are different: in Montana schools, 83.8 percent of students are white, 11.4 percent American Indian, 2.6 percent Hispanic, 0.9 percent Asian, 1.0 percent Black, and 0.3 percent Pacific Islander. In the 2008-2009 school year, Montana had 52 k-12 public school districts, in a total of 429 districts overall. The total number of schools for the 2008-2009 school year was 829 (Montana Office of Public Instruction, 2009). Management of these schools and the programs they implement is a significant task.

Montana's School Mental Health program, Comprehensive School and Community Treatment (CSCT), currently has nine subcontracting entities in the state. In the 2008-2009 school year, a total of 191 schools and 80 school districts subcontracted for CSCT services.

Academic Year	Schools Districts Contracting CSCT Providers	School Contracting CSCT Providers
2008-2009	80	191
2009-2010	80	194
2010-2011	84	212

Figure 1: Comprehensive Schools and Community Treatment Contracts by Academic Year (Montana Office of Public Instruction, 2010)

Figure 1 shows CSCT contract awards by school district from the 2009 academic year (AY) to the present. From AY 2008-09 to AY 2010-11, the total number of contracts increased by 21, an 11 percent rate of change. This increasing trend of 191 to 212 providers in 84 school districts underscores the need for research-based decisions on the part of the state.

Although the structure of CSCT may change as a result of Administrative Rules revision, it is important to acknowledge and recognize areas of strength already within CSCT. **Figure 2** demonstrates the strengths to the CSCT program, which include but are not limited to:

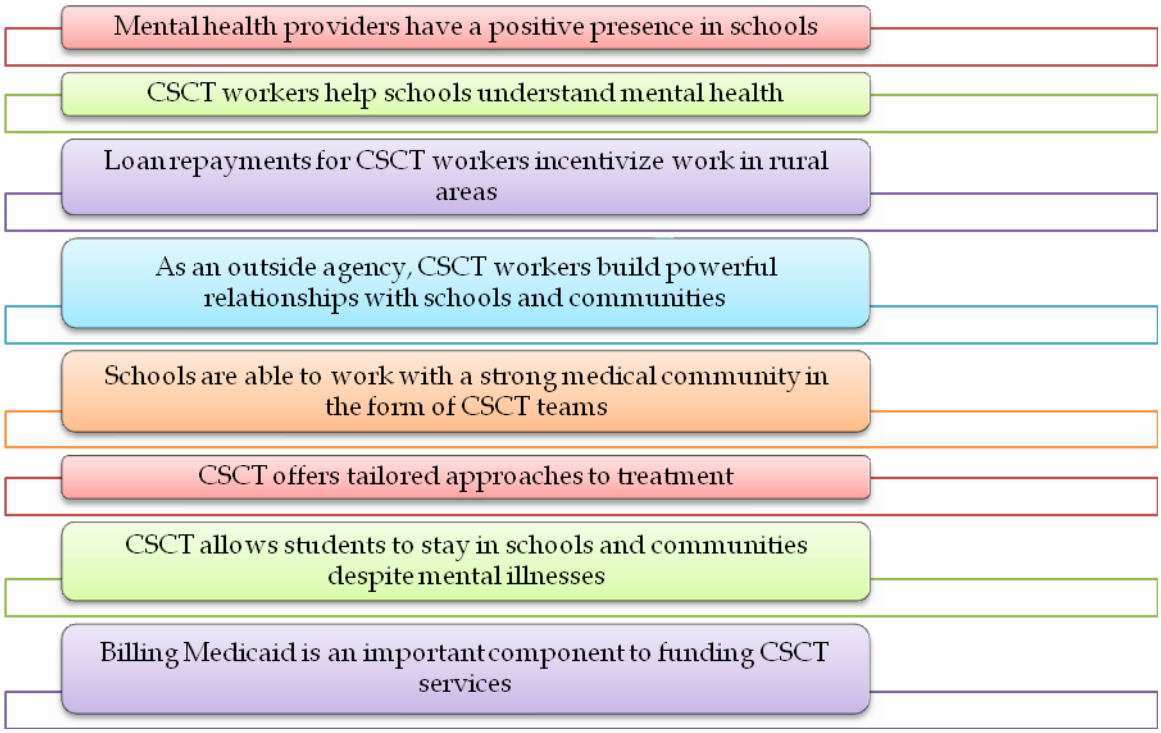

Figure 2: Strengths of CSCT Programs, as Proposed by Author

Issues specific to Montana's CSCT program are not uncommon across the spectrum of mental health providers in other states. Researchers, state workers, school employees, community members, policy-makers, mental health professionals, parents, and children work diligently to develop the most comprehensive SMH framework possible. Montana is no exception.

Still, it is important to analyze the weaknesses in CSCT implementation, which include gaps in: training; services to tribal and rural communities; access to resources; employee retention; collaboration within school systems; mental health roles; program development, assessments and evaluations; and financing mental health services in schools, to name just a few. This report seeks to highlight the disparities in Montana's CSCT program, in light of national trends and best-practices implemented in research-based approaches.

The structure of this report begs some explanation. **Section IV** defines School Mental Health from a research-based approach. **Section V** explains an alternative framework to School Mental Health programs called Quality Assessment and Improvement, the components of which serve as the outline for the different areas of study in **Section VI**. **Sections VI through VIII** analyze specific fields within the CSCT in Montana, and provide model applications of these fields, describe pertinent Administrative Rules, and outline specific recommendations for revisions of Administrative Rules. **Sections IX and X** outline general recommendations for the process of changes to Administrative Rules and changes to funding for CSCT. **Appendices I-IV** provide supplemental material as referenced in individual sections.

Section IV: Defining School Mental Health

Though there are many definitions of School Mental Health among social science researchers, common themes and concepts reoccur. Weist and Paternite (2006) present a thorough overview of mental health definitions, incorporating key concepts. **Figure 3** recapitulates their results. School mental health:

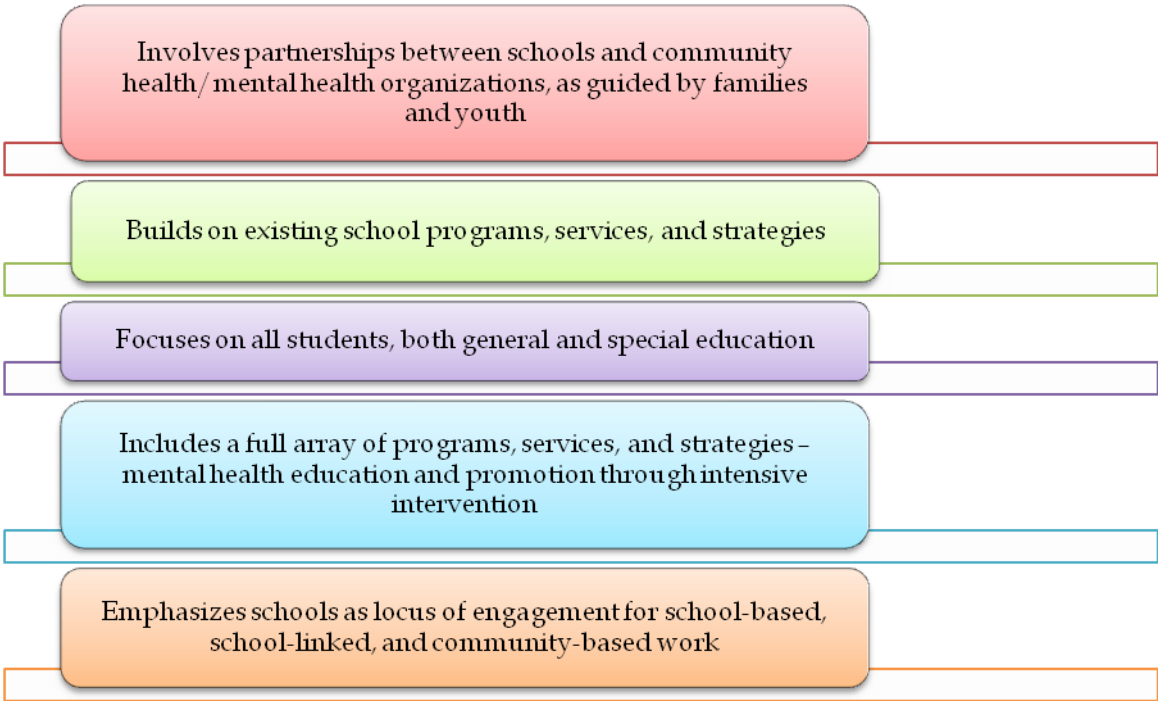

Figure 3: Definitions of School Mental Health (Weist, "NASBHC Power Point", 2006)

The definitions Weist and Paternite (2006) offer address the limitations of traditional School Mental Health and consider more comprehensive and integrated services that expand from individual students to the families, schools, and communities of those students. Weist and Paternite (2006) incorporate research within these definitions, including more effective, integrated, and comprehensive ways of service delivery.

Section V: Quality Assessment and Improvement (QAI)

Researchers for the Center for School Mental Health (CSMH) emphasize the importance of Quality Assessment and Improvement (QAI) frameworks, which provide alternatives to SMH in keeping with the comprehensive, research-based definitions proposed by Weist and Paternite (2006). "The failure to advance systemic quality assessment and improvement (QAI) frameworks in [School Mental Health]," argues Evans, et al. (2007), "contributes to a picture of poorly planned, implemented and evaluated services that are having superficial, if any, benefit" (p. 2).

The authors of "Quality and school mental health" (2007) argue that if QAI frameworks are not in place, the connection of training, practice, research, and policy into system transformation is less likely to occur. These system transformations themselves are "being called for by mental health, education, and other child serving systems" (Evans, Weist, & Serpell, p. 2). **Figure 4** shows what is incorporated into quality School Mental Health, as proposed by Weist and Paternite (2006), and take into account the frameworks of QAI as proposed by Evans et al. (2007):

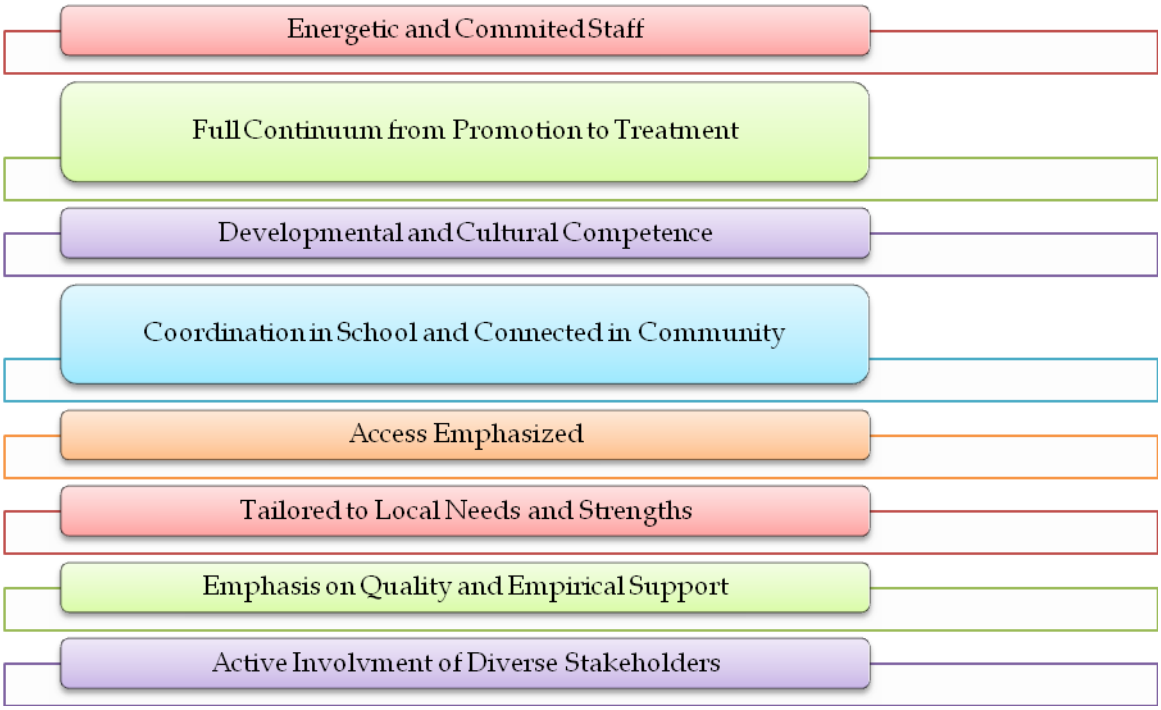

Figure 4: Attributes of Quality Assessment and Improvement (Weist, "NASBHC Power Point", 2006)

These best practices for QAI are not exclusive to QAI alone, and may already exist in SMH models across the country. Whereas, attributes of past SMH services may put emphasis on licensure of service-providers, individual therapies for students, and spreading of service providers across multiple schools, these attributes (**Figure 4**) expand SMH practices in the service of the systems that implement SMH programs.

Detailed Principle	Section V Subheading
All youth and families are able to access appropriate care regardless of their ability to pay	Prevention and Early Intervention
Programs are implemented to address needs and strengthen assets for students, families, schools, and communities	Family-School-Community; Training; Evidence-Based Practice
Programs and services focus on reducing barriers to development and learning, are student and family friendly, and are based on evidence of positive impact	Outcomes and Evaluation
Students, families, teachers and other important groups are actively involved in the program's development, oversight, evaluation, and continuous improvement	Outcomes and Evaluation; Family-School-Community
Quality assessment and improvement activities continually guide and provide feedback to the program	Outcomes and Evaluation
A continuum of care is provided, including school-wide mental health promotion, early intervention and treatment	Promotion
Staff hold to high ethical standards, are committed to children, adolescents, and families, and display an energetic, flexible, responsive, and proactive style in delivering services	Evidence-Based Practice
Staff are respectful and competently address developmental, cultural, and personal differences among students, families, and staff	Supervision
Staff build and maintain strong relationships with other mental health and health providers and educators in the school, and a theme of interdisciplinary collaboration characterizes all efforts	Interdisciplinary Collaboration
Mental health programs in the school are coordinated with related programs in other community settings	Youth Leadership Opportunities

Figure 5: Principles for Expanded School Mental Health and Subheadings for Section V, Pillars for ESMH Practice (Center for School Mental Health, 2009)

The Center for School Mental Health's research on QAI (2009) outlines a set of ten principles which incorporate the research-based attributes of QAI, as proposed by Weist (2006), "reflecting the vision of best practice for the expanded school mental health (ESMH) field." The CSMH developed their principles through a nationwide survey and series of interactive forums with school health, mental health, and education staff.

The first column of **Figure 5** shows the principles for Expanded School Mental Health developed by CSMH. The second column of **Figure 5** shows the separate subheadings, as found in **Section VI**: Pillars for Expanded School Mental Health Practice, which discusses how the Comprehensive School and Community Treatment (CSCT) Administrative Rules may be reevaluated. The listing here provides the rationale for the component parts of **Section VI**, as they relate to principles of ESMH.

Section VI: Pillars for Expanded School Mental Health Practice

Many variables are involved in ensuring high-quality and effective School Mental Health (SMH) practices. Research-based definitions of School Mental Health (SMH), Quality Assessment and Improvement (QAI) frameworks, and research-based principles for Expanded School Mental Health (ESMH) all engender their own complications, but when implemented together, approach comprehensive systems change. The purpose of this section is to show how the latter steps of ESMH might translate to the state of Montana's School Mental Health program, CSCT.

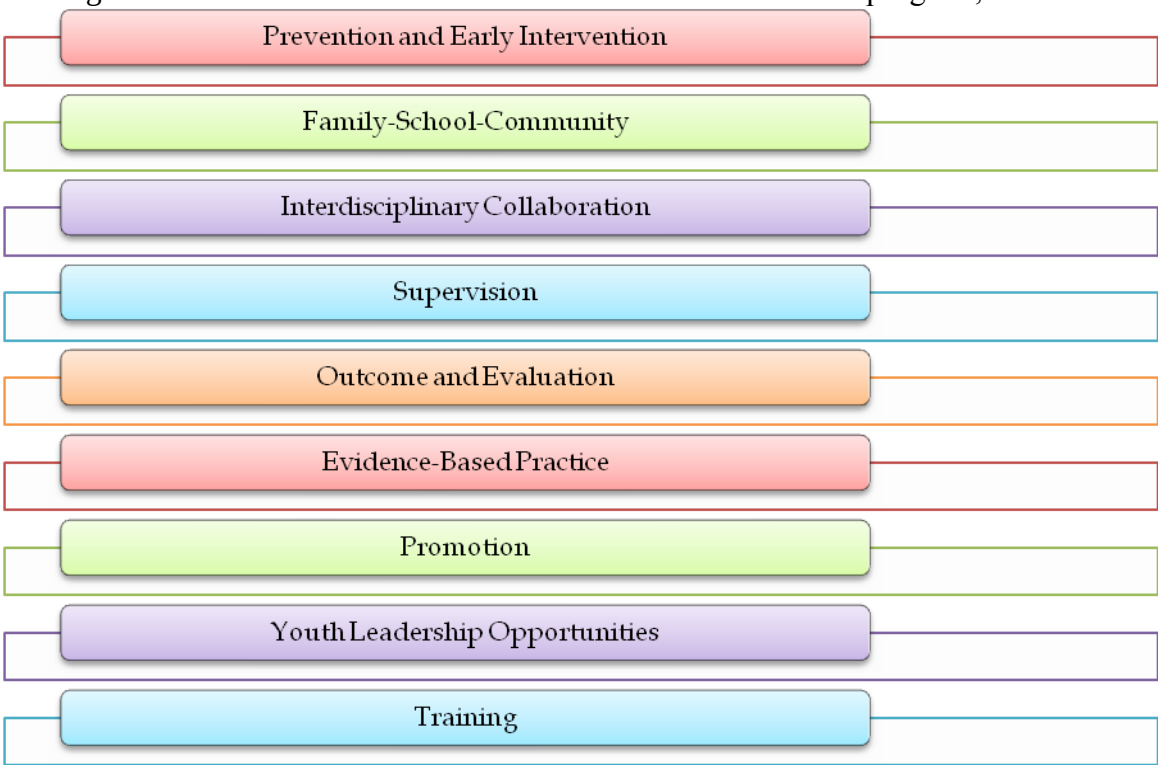

Figure 6: Components to Integrated and Comprehensive (Expanded) School Mental Health

Figure 6 illustrates components to ESMH, as proposed by the author, and correlates with **Figure 5**, Principles for Expanded School Mental Health and Subheadings for Section VI of this document, Pillars for ESMH Practice. Each subheading offers suggestions about how the current Administrative Rules for Montana's Comprehensive School and Community Treatment (CSCT) program might be revised. Each component has an example that shows its relevance to School Mental Health in Montana.

6.1 Prevention and Early Intervention

The Illinois statewide strategic plan for Building a Comprehensive Children's Mental Health System (2005) argues:

> Research clearly demonstrates that children's healthy social and emotional development is an essential underpinning to school readiness, academic success, health, and overall well-being. Prevention and early intervention efforts have been shown to improve school readiness, health status, and academic achievement, and to reduce the need for more costly mental health treatment, grade retention, special education services, and welfare supports. Many mental health problems are largely preventable or can be minimized with prevention and early intervention efforts (p. 2).

Nationally, Illinois is a leader in School Mental Health, owing to their credibility among social scientists and SMH technical assistance centers. Other states such as Michigan have discussed Illinois' programming as part of their own efforts to improve SMH. As an example of appropriate ESMH, Illinois' particular stance on prevention and early intervention serves as a model for Montana.

A report of the Surgeon General (1999) offers that preventive interventions "have been shown to be effective in reducing the impact of risk factors for mental disorders and improving social and emotional development" (U.S. Department of Health and Human Services).

Administrative Rule(s):
37.86.2224 THROUGH 37.106.1974 AND
37.87.803

Model Application:
In Montana, one CSCT team working with early childhood intervention provides services at Jefferson School, a preschool within the Missoula County School District. According to the Missoula School District, Jefferson is the only preschool in Montana providing intensive CSCT services at the early childhood level (Nierson, 2010). All of the students at Jefferson are below the diagnosable threshold age of six.

Jefferson's focus on early childhood intervention is an evidenced-based practice that emphasizes team success. Aside from doing best practice by working with preschool students, **Figure 7** shows other factors make for highly successful CSCT team members:

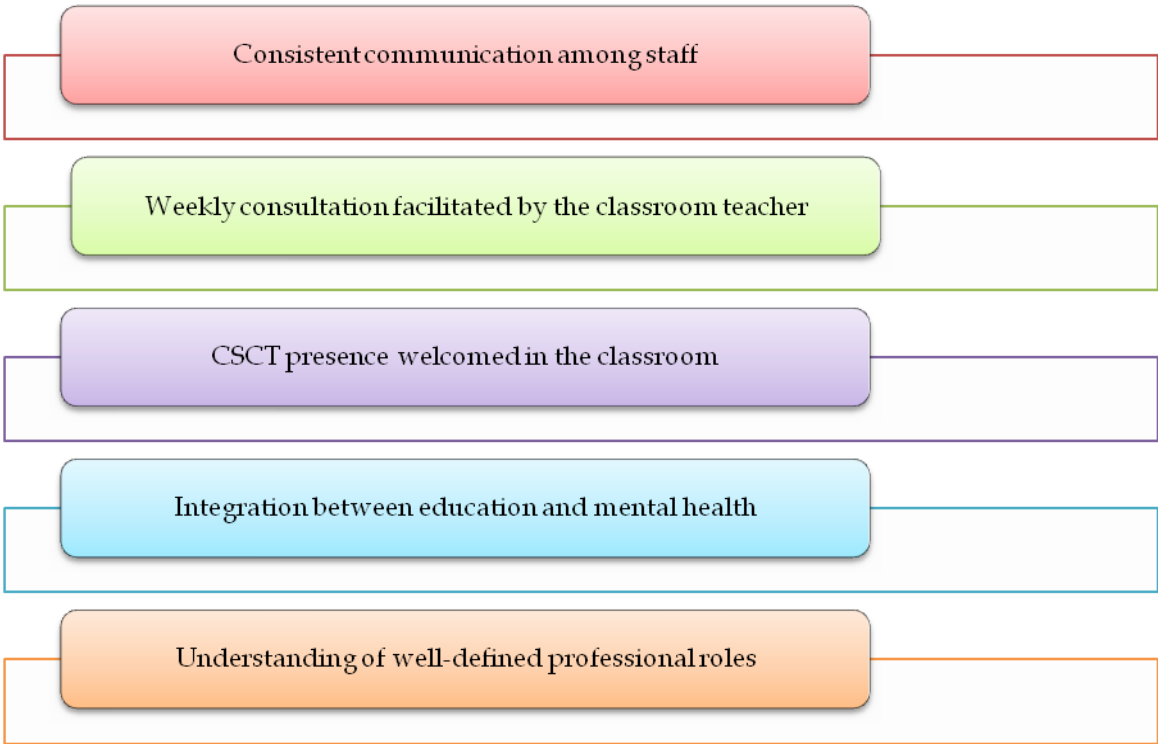

Figure 7: Factors for CSCT Success, Jefferson Preschool (Gillispie, 2010)

Kathleen Nierson, Missoula School District Special Education Director, argues the best partnerships include accountability, results, and communication, and believes that empowering schools to have more involvement with CSCT is important. Empowering schools to have more involvement with CSCT has the possibility to increase prevention and early intervention of mental health services within school systems by helping CSCT teams become more inclusive, integrated, and active participants.

The Missoula School District is highly satisfied with the CSCT teamwork at Jefferson for the following reasons (**Figure 8**):

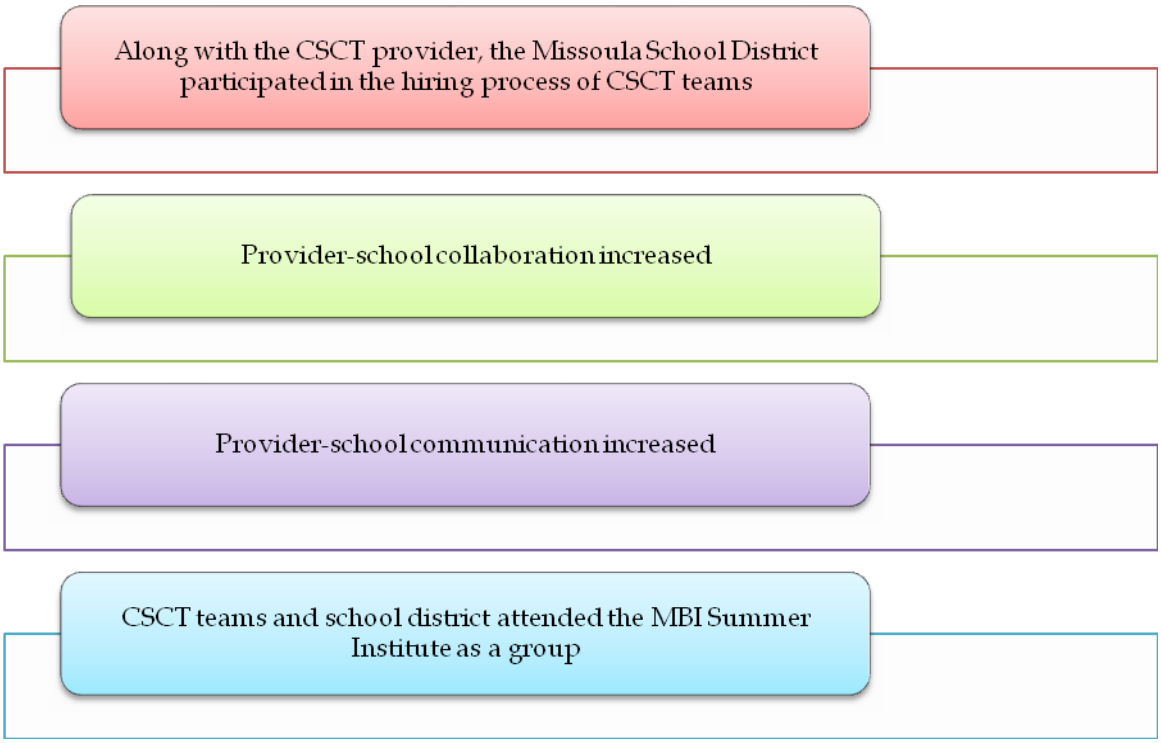

Figure 8: Factors for School District Satisfaction with CSCT, Jefferson Preschool (Nierson, 2010)

Recommendations

The CSCT Administrative Rules are treatment focused. Re-rewriting the CSCT Rules is an opportune time for Montana to add prevention and early intervention language into Rule changes. For example, language including "children or youth at risk" may be more comprehensive than the current language, those diagnosed with a "Serious Emotional Disorder." Administrative Rule language could expand Rules to include "students with disabilities."

Revise CSCT Administrative Rules to include the language of "prevention" and "early intervention" AND revise 37.87.303 to expand the definition of Serious Emotional Disturbance.

6.2 Family-School-Community

One of the national shifts occurring in SMH is in building cohesive working relationships between families, schools, and communities. Not only are the voices of family and youth critical components to effective School Mental Health, but family and community voices are increasingly changing in areas of research. McNiff and Whitehead (2010), practitioners of qualitative research, state that action research (a form of qualitative methodology) has validity at the individual level; this quality is known as personal validity and is better defined as the testing of claims against the critical feedback of others. Public legitimization, then, is the ongoing process of testing these claims over time (p. 55).

By design, action research scientifically proves youth need to be involved in family decision-making processes, share power-based decisions, and acknowledged for their experience and expertise as youth. At the school level, under the methodologies of action research, family and youth are active members of the administrations' decision-making processes. When youth

are at the table and part of the decision-making processes, families-schools-communities begin changing from within, and shifts begin taking place within communities as a result.

Four major SMH technical assistance centers in the United States discuss family-school-community partnerships as being critical components to quality, integrated, and comprehensive Expanded School Mental Health. **Figure 9** demonstrates the arguments for family-school-community partnerships according to universities at Georgetown, Maryland, California Los Angeles, and the National Assembly in Washington, D.C.

Center for Child and Human Development Georgetown University	**Center for School Mental Health University of Maryland**	**Center for School Mental Health Project UCLA**	**National Assembly on School-Based Health Care Washington, D.C.**
"Collaborating with families and youth, communities, local agencies, national organizations, and universities in developing, designing and conducting research projects."	"Programs are implemented to address needs and strengthen assets for students, families, schools, and communities."	"From a policy perspective, efforts must be made to guide and support the building of collaborative bridges connecting schools, family, and community."	"Students thrive most when parents and caregivers are involved in their children's school lives and engaged as key collaborators in providing emotional support and reducing external stressors (e.g., sibling conflict, loss, violence) that affect mental health."

Figure 9: Arguments for Family-School-Community (OSEP Technical Assistance Center, 2010)

National Technical Centers, as leaders in research-based results for Expanded School Mental Health, agree that the family-school-community relationship is imperative.

Administrative Rule(s):
The CSCT Administrative Rule 37.106.1956 (1) (a), states the CSCT program must be able to provide therapeutic services to "individual, group and family." Comprehensive School and Community Treatment in its title alone speaks to "community" involvement. Though the language of "family therapy" is included in the Administrative Rules, the gap between Rule and practice that includes families in SMH services has not been evaluated.

Model Application:
Wraparound is "a facilitated team-based process involving child, youth, his/her family, and professional and natural supports who are involved. This process results in strengths-based individualized plans that lead to achieving positive outcomes [for families, youth, and providers]" (Vandenberg & Haws, 2010). Susan Mears with the Nevada Division of Child and Family Services, Professors Joanne Yaffe and Norma Harris of the University of Utah (2009), studied *Wraparound* to compare the outcomes of youth receiving the *Wraparound* approach with youth receiving traditional child welfare case management. Their research demonstrated that youth receiving *Wraparound* showed significant improvement on the Child and Adolescent Functional Assessment Scale (CAFAS) when compared with youth receiving traditional child welfare services (p. 678).

In an article published in the *American Journal of Community Psychology*, Bruns, et al. (2010), argue: "*Wraparound* aligns strongly with the consumer and family movement, fills an increasingly notable gap in the continuum of care proposed by the public health framework, and

serves a central role in the application of the systems of care framework" (p. 328). The authors also maintain, "Family organizations are often strong supporters of *Wraparound* because its philosophy of care stresses family empowerment and highlights the importance of building and strengthening families' social community ties" (p. 318).

The National Wraparound Initiative (NWI) suggests that *Wraparound* is: family-, team-, and community-based, depends on the collaboration and strengths of its practitioners, includes natural supports and unconditional, individualized care, is culturally and linguistically competent, and, finally, is outcomes-based and cost-responsible. **Figure 10** shows NWI's concept of the phases and activities of *Wraparound* practice:

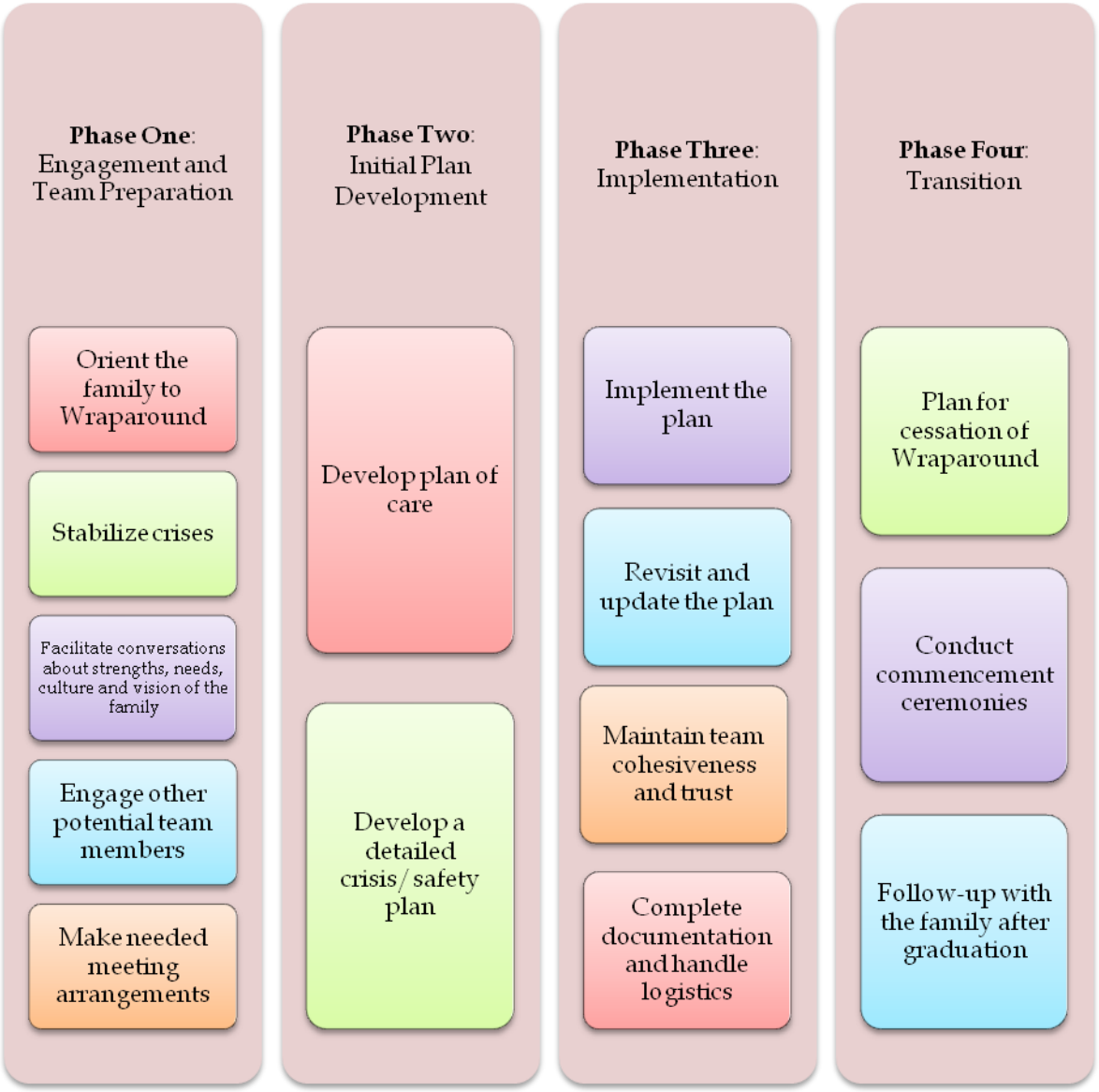

Figure 10: Phases and Activities of *Wraparound* (Vandenberg & Haws, 2010)

Vandenberg (2010) outlines four components of implementation that make *Wraparound* well supported at a systemic level: 1) Coaching and Supervision; 2) Professional Development Planning; 3) Certificate of Credentialing; and 4) Supervision (High fidelity wraparound, 2010). These components of *Wraparound* correlate with the family-school-community continuum of Expanded School Mental Health, as proposed by the author.

Recommendations:
It could be assumed that by the nature of a CSCT therapist working within a school environment, individual and group therapies are the primary ways CSCT teams implement services in Montana. Should a thorough evaluation of current CSCT services show that CSCT teams omit family and community involvement, Rule changes are an opportunity to add language that will more clearly define the expectations of CSCT providers to include family and community involvement.

As written, it could also be assumed that CSCT providers can only offer and bill for services within the schools themselves, pursuant to their ability to bill Medicaid. In some therapeutic situations, however, circumstances require that CSCT providers offer services that are not directly billable to Medicaid, leaving the service directly unpaid and thereby undelivered. Revisions to Administrative Rules could expand or strengthen language of oversight of non-billable services, especially in situations where students may not be present on the school site or in situations where the extenuating circumstances of an individual case require the CSCT provider to work off-campus. In short, language administering greater oversight of non-billable services of CSCT providers is necessary.

Before the Administrative Rules of CSCT are revised, the Montana Office of Public Instruction and the Montana Department of Public Health and Human Services may consider researching CSCT teams who already implement the ethic of offering services despite non-billable constraints. It will be important that the Administrative Rule language parallels the state's expectations, yet provides enough flexibility for implementation. If Medicaid is the only and/or primary funding avenue for CSCT services, and if this is proven through an evaluation of CSCT services in schools across Montana, Administrative Rules could also add language to adjust organization and school accountability toward the finances of CSCT teams, to ensure an increase in family and community involvement.

6.3 Interdisciplinary Collaboration

Building bridges, enhancing interdisciplinary collaboration, and developing common language between mental health professionals and education professionals and programs will greatly improve Expanded School Mental Services and outcomes. Researchers at the University of South Florida, in a document titled "School-Based Mental Heath Empirical Guide" (2006) maintain that gaps exist between research in education and research in mental health, "with neither citing each other's work." The authors continue that, "[t]here are bridges to build here" between research and implementation (p. 6).

Bronstein (2003) presents a model of interdisciplinary collaboration for social workers, representing "optimum collaboration between social workers and other professionals" (p. 297). Bronstein presents five core components to interprofessional processes: 1) interdependence; 2) newly created professional activities; 3) flexibility; 4) collective ownership of goals; and (5) reflection on process. Bronstein describes interdependence as referring to:

> the occurrence of and reliance on interactions among professionals, whereby each is dependent on the other to accomplish his or her goals and tasks. To function

> interdependently, professionals must have a clear understanding of the distinction between their own and their collaborating professionals' roles and use them appropriately (2003, p. 299).

Bronstein furthers, "the presence of [influences of functioning members] supports interdisciplinary efforts, whereas their absence presents barriers to its occurrence" (2003, p. 302).

Expanded School Mental Health involves more disciplines than traditional approaches. Bronstein's model for interdisciplinary efforts supports what national leaders in SMH propose as being critical components to more comprehensive or Expanded School Mental Health. One of the key components to ESMH is the delivery of services through multiple disciplines such as education, social work, nursing, counseling, psychiatry, and psychology (Flaspohler, Anderson-Butcher, Paternite, Weist, & Wandersman, 2006). As multiple professionals work with similar students within school systems whose focus and core responsibility involves student academic achievement, building bridges, enhancing interdisciplinary collaboration, and developing common language between mental health and educational professionals becomes more critical than ever.

Administrative Rule(s):
37.106.1956, which discusses CSCT program services AND
37.106.1960, which discusses the staffing, training, and definition of CSCT providers.

Model Application:
Communities of Practice (CoP) are models of interdisciplinary collaboration where professionals in many disciplines share ideas and strategies for the betterment of their professions. "A community of practice (CoP) is a group of professionals who voluntarily come together because they care deeply about the same issue and they agree to interact routinely to improve practice around that issue" (IDEA Partnership, 2010). The IDEA Partnership at Alexandria, Virginia, and the Center for School Mental Health, based at the University of Maryland School of Medicine, have worked toward building and providing ongoing support to a National Community of Practice (NCoP) that organizes a spectrum of federal agencies through local consumers.

This National CoP has representation from the professional fields of mental health, general education, special education, and includes members from family organizations. Such an amalgamation of stakeholders collectively strives to "bring diverse organizations into a working relationship around their common interests; bring stakeholders into the work of state education agencies as allies; and bring fresh approaches to persistent problems by uniting decision-makers, practitioners, and consumers around a common goal" (Communities of Practice, 2010). According to IDEA, "over 33 states see the value of the CoP strategy and choose to participate in Communities of Practice at some level" (2010). Montana will host their first face-to-face CoP symposium in Helena in March 2011, as facilitated by IDEA.

Montana's development and participation in a statewide CoP is not only an opportunity for representatives working from mental health, general education, special education, and family organizations to share strategies in SMH, but also an opportunity for Montana CSCT providers to begin increasing collaboration across the state.

Recommendations:
Administrative Rules AND school/CSCT provider contracts could add language to integrate interdisciplinary collaboration. As written, CSCT Administrative Rules do not effectively consider interdisciplinary collaboration, nor do they adequately recognize mental health professionals already in place within schools systems. Language in school/CSCT contracts should be analogous to the revised language of CSCT Administrative Rules. The state of West Virginia's SMH contract provides a good example for the state of Montana to review as a model of interdisciplinary collaboration in practice (see **Appendix I**: State of West Virginia School Mental Health Contract).

6.4 Supervision
Ongoing supervision is critical to professional practice and ongoing professional development. However, supervision can be costly to an agency, or in the case of SMH, a school budget. Supervisors often become consumed with administrative responsibilities that affect supervision consistency (Evans & Weist, 2004). In an article published in *Clinical Child and Family Psychology Review,* Evans and Weist (2004) write:

> Our own experience supervising school mental health practitioners suggests that when a case is not consistently reviewed in supervision, it is more likely to involve treatment with an eclectic collection of informally implemented techniques that are less likely to be effective than treatment that is regularly reviewed (p. 264).

Supervision allows for professional development opportunities and opportunities to discuss ethical dilemmas an employee may be experiencing, thereby creating a more professional and ethical atmosphere in which to work; in the case of SMH, one that results in better treatment of individuals.

Milne and James (2003) discuss in the *British Journal of Clinical Psychology* that it is important to understand how supervision training will impact the supervisee (p. 56). When supervisors provide feedback to their staff, results show "improved competence and greater maintenance" (p. 57). Coulder and Sellars (2004) argue that when supervision is more "formalized and offers scope for individual agency, it is an ethical form of surveillance" that "can be advantageous to individual practitioners and to professional groups enhancing practice" (p. 264).

Administrative Rule(s):
Administrative Rule 37.106.1960 (4), which states "A CSCT program must employ or contract with a program supervisor who is knowledgeable about the service and support needs of children and adolescents with serious emotional disturbances. The program supervisor may be a member of a team providing direct services."

Model Application:
University of Montana Research Professor Dr. Jim Caringi studies secondary traumatic stress and burnout and consults on self-care. His research incorporates supervision and emphasizes ongoing supervision in the professional work environment. According to Caringi, consistent supervision is linked to reducing long-term burnout, especially in areas where professionals have daily contact with children, youth, and families who live in poverty, experience violence in the home, or may have experienced repeated abuse, neglect, or trauma (Secondary traumatic stress,

2010). Professional licensure requires supervision as a component in the licensing process. Supporting supervision needs is important and contributes to employee retention and satisfaction.

Recommendations:
Various professions have supervision requirements and educational backgrounds that affect the needs of employees. Supervision may be an area the Montana Office of Public Instruction (OPI) or the Montana Department of Public Health and Human Services (DPHHS) could receive more valid input from current CSCT workers, specifically those who carry a license or are working on attaining a license. The Administrative Rule could add language that would support supervision needs of employees such as discussing cases, doing site visits, and allowing for the flexibility of peer-to-peer supervision. If supervision time is limited to administrative responsibilities such as billing and paperwork, the chance of CSCT workers feeling supported may decrease, leading to employee dissatisfaction and higher turnover. The OPI and DPHHS could research CSCT supervision through qualitative and quantitative research methodologies by means of surveys and CSCT focus groups.

To broaden supervision requirements in the Administrative Rules, both the CSCT therapist and aide positions could be expected to receive regular supervision. For example, the Administrative Rule language could be more prescriptive in requiring CSCT workers to receiving training on a weekly or bi-weekly basis. The Administrative Rules could be specific about supervision hours, length of supervision time, and be worded similarly to professional licensing requirements. More so, Administrative Rules could strengthen supervision requirements by asking an MSW or LCSW to be supervised by an LCSW and an MA or LCPC to be supervised by an LCPC, as per professional protocol.

6.5 Outcomes and Evaluation

Using research to support the professional and organizational work environment and evaluating services is a critical component to comprehensive SMH. Dr. Mark Weist (2010) suggests going beyond evaluating services and programs through supervision, to evaluating how professionals work together (Personal communication). Establishing the practice of evaluating work performance increases the effectiveness and quality of services delivered. One component included in the Quality Assessment and Improvement (QAI) framework, a researched framework promoted by the Center For School Mental Health, is to "emphasize quality and empirical support" (Evans, Weist, & Serpell, 2007, p. 24).

However, connecting science to practice is a challenge nationwide. Dr. Abe Wandersman, a professor at the University of South Carolina, studies the gap between research and implementation. Getting to Outcomes (GTO) was an accountability program he developed with colleagues Chinman and Imm (2000). As a guide, GTO directs readers from the needs-assessment process to a place of ensuring sustainability (Getting to outcomes: a results-based approach to accountability). In one interview regarding GTO (2009), Wandersman discusses the assumptions about science and practice:

> Researchers say, 'We did the research, we know what works, and just do it.' It's as if the researchers have wrapped these really valuable things in Christmas paper and given them to practitioners, and all the practitioners are supposed to do is unwrap them. In reality, there's a lot more to launching a program than that. While drawing on the evidence base is necessary, he says, it's not enough (Clay, p. 48).

The GTO approach has been recognized by the American Evaluation Association, an organization of over 5,500 members internationally (About us, 2010).

Data collected from schools, communities, families, and state systems provides a means of looking at the systems in place, not at targeted individuals. The Positive Behavioral Intervention and Supports (PBIS) system offers a strong example of how data is used on a system-wide level to help school personnel become more comfortable with evaluation or services (OSEP Technical Assistance Center, 2010). Creating a systems culture wherein using research and evaluating services and programs becomes the norm, the practice of evaluation will increase.

Administrative Rule(s):
37.106.1919 (1), which states, "Each mental health center shall implement and maintain an active quality assessment program using information collected to make improvements in the mental health center's policies, procedures, and services."

Model Application:
Some states have found ways to increase participation around the implementation of research, evaluation, and collecting data through the development of community and university partnerships. Researchers in Ohio (2007) wrote a paper about community-university (C-U) partnerships to discuss the benefits of relationships developed between these entities. The authors point out that "Community-University (C-U) partnerships create a mutually beneficial situation. They bring valuable resources to communities to help them address the needs of youth and families, while also providing unique opportunities for education, training and research for university students and faculty members" (Owens, Dan, Alvarez, Tener, & Oberlin, 2007, p. 1). The authors continue:

> In fact, integrated and interdisciplinary partnerships are becoming the standard for providing quality mental health care. One mechanism for closing the gap between science and practice is the development of C-U partnerships that strategically enhance community capacity to identify and address local needs, while also informing the advancement of science (2007, p. 1).

Ohio considers C-U partnerships to include: four-year colleges, tribal colleges, and community colleges (Owens, Dan, Alvarez, Tener, & Oberlin, 2007).

Across the state of Montana, there are 25 higher education institutions, including one tribal college on each of the seven reservations with land designation. Higher education exists in most all geographic regions across the state of Montana, including rural areas where accessing and retaining professionals and resources can be difficult. Increasing C-U partnerships could be one strategy to expand and strengthen research and evaluation for CSCT programs.

Ohio has become a national leader in their Community-University (C-U) partnerships through the development of the statewide Ohio Effective Practice Registry. In order that programs become recognized and part of the Ohio registry, SMH programs are evaluated for: 1) their evidence of effectiveness; 2) strengths of sustainability plans and transportability of programming; and 3) strengths of partnerships with community members (Paternite, 2010).

The C-U partnerships help programs rethink how they affect communities. Where programs may have struggled with how to evaluate or assess their work, university partnerships have been able to provide tools and new ideas about how to evaluate (Owens, Personal communication, 2010). By design, the structure of the Ohio registry allows for flexibility in programs across the state of Ohio, yet is able to set consistent expectations and program standards. Ohio's registry highlights each program's implementation of evidenced-based

practices, work with schools, families, and community collaborations. Ohio's full registry application is available in **Appendix II**: Ohio Effective Practice Registry Application.

Recommendations:
Administrative Rules could be revised by including language to hold schools more accountable so as to maintain an active quality assessment of CSCT services within a school environment. However, individual therapists and counselors who might come from a work environment of having their own practice may not be accustomed to having their work evaluated (Weist, Personal communication, 2010).

Currently, there has been no formal assessment or evaluation of the CSCT program in Montana. Evaluation here includes collecting data and using data to inform decisions that are made in a collaborative method. Administrative Rules could be strengthened through the implementation of a statewide evaluation of CSCT every two to three years. This evaluation could happen through both quantitative and qualitative research methodologies.

6.6 Evidence-Based Practices
Evidence-based practices (EBP) are often poorly realized and so contribute to the gap of research to practice as discussed by Wandersman (2000). The EBP programs are often expensive, require training, and only target a specific group or issue. Agencies, schools, and communities are often not equipped to maintain the capital or continuation costs of such programming, and EBP programs are subject to inconsistent effectiveness, owing to these constraints. Properly preparing agencies, schools, and communities for the expectations of EBP programming is key to successful implementation.

Administrative Rule(s):
37.106.1960, which discusses the staffing, training, and definition of CSCT providers.

Model Application:
Wandersman (2003) writes about community science as a way of improving "the quality of life in our communities by improving the quality of practice of treatment, prevention, health promotion, and education," which he defines as, "an interdisciplinary field which develops and researches community-centered models that enable communities to use evidence-based interventions more effectively and efficiently" (p. 227).

In **Figure 11**, Green (2001) refers to four gaps between research and practice. Overall, Green (2001) suggests a single "results-based approach to accountability that bridges research and practice" (Wandersman, 2003, p. 230). Implementing strategies that address the gaps between research and practice with evidence-based practices is a form of effective community science and provides a model framework for conceptualizing adaptations to CSCT care.

Cap Between Research and Practice	The gap between efficacy of best practices created by research and effectiveness when implemented by practitioners	The gap between 'best practices' research and most appropriate adaptation when adopted for a particular target population	The gap between achieving individual behavior change with middle class versus lower class	The gap between research-driven (operate from research-centered medical models) roles versus roles that local practitioners, community groups, agencies, and governments need to play to ensure that future research is useful to local needs
Possible Solution	'Best practice' as process rather than as packaged interventions	Emphasize control by practitioner, patient, client, community, or population	Emphasize local evaluation and self-monitoring	Research on the tailoring process and new technologies

Figure 11: Gaps between Research and Practice and Possible Solutions (Wandersman, 2003, p. 230)

Recommendations:

Administrative Rules could include language that broadens how schools and CSCT teams consider working with evidence-based interventions through training structures. Due to the precautions offered by Wandersman (2003), the implementation of EBP through revised CSCT Administrative Rules should take place over a long-term period, include consistent training and oversight, and include a thorough review of costs associated with implementation.

Implementing components to ESMH work toward systems change, not individual change. If an entire school works to integrate academics with mental health and considers the entire well-being of an individual student as interconnected, the possibilities for school cultures to broaden their understanding will positively affect the family-school-community continuum.

6.7 Promotion of Mental Health

Youth Motivating Others through Voices of Experience (Youth MOVE) is a national organization "devoted to improving services and systems that support positive growth and development [of youth] by uniting the voices of individuals who have lived experience in various systems, including mental health, juvenile justice, and child welfare," offering opportunities for youth to become leaders. With children's mental health as a focus of their work, Youth MOVE advances the "empower [ment of] youth to be equal partners in the process of change" (National Federation of Families for Children's Mental Health, 2010).

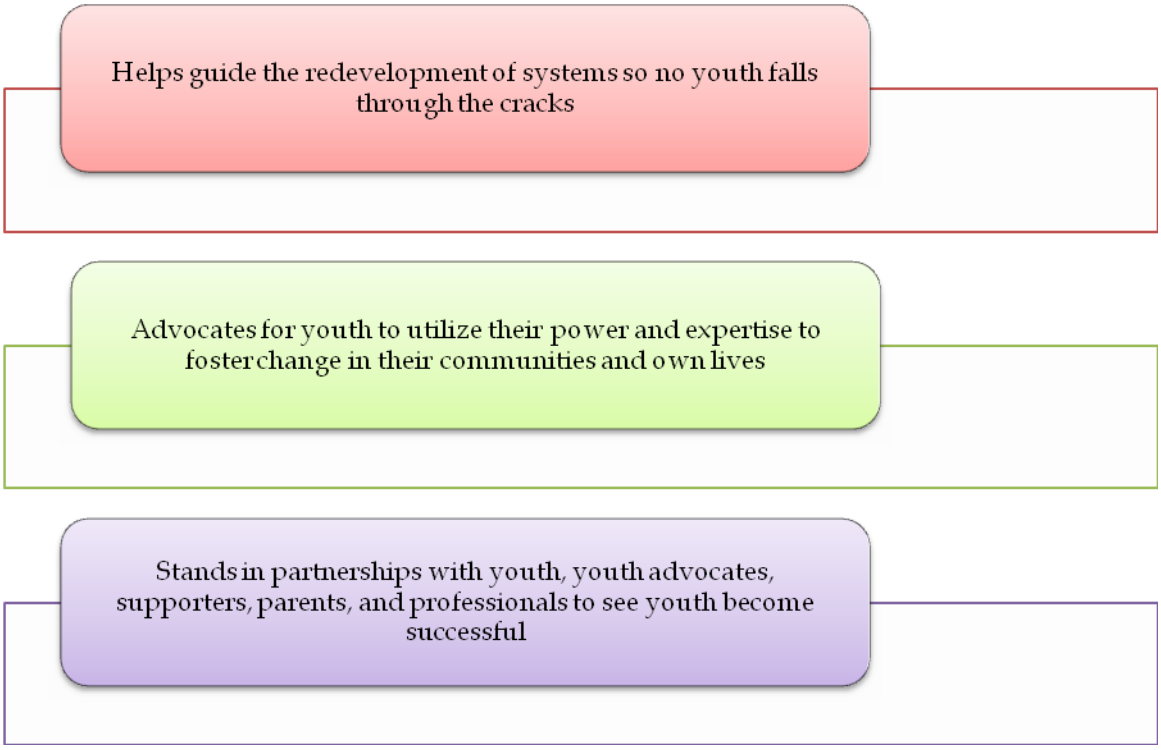

Figure 12: Attributes of Youth MOVE (National Federation of Families for Children's Mental Health, 2010)

Youth MOVE exists to promote the national vision that "every youth person that enters a youth-serving system is being prepared for life through genuine opportunities and authentic youth involvement throughout all systems level" (National Federation of Families for Children's Mental Health, 2010). **Figure 12** shows the qualities of Youth MOVE as a systems-change agent. Youth MOVE advocates for several youth-focused approaches to systems change. **Figure 13** illustrates the different methods of their work:

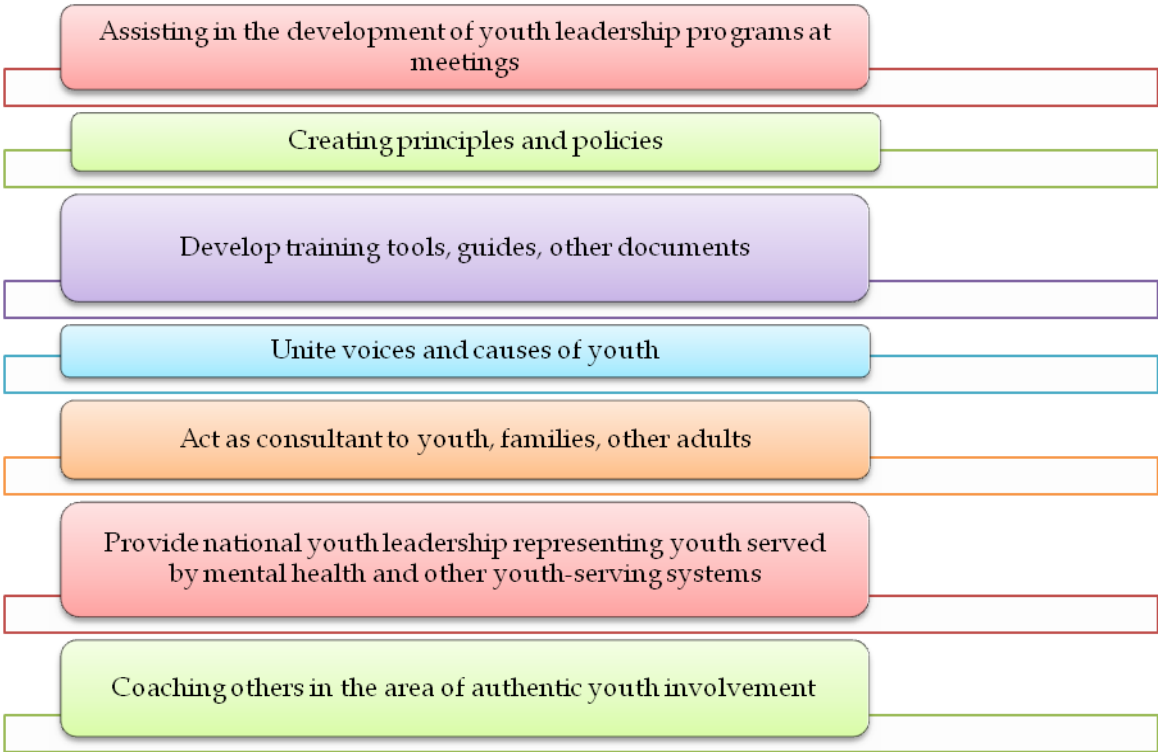

Figure 13: Avenues of System Change, Youth MOVE (National Federation of Families for Children's Mental Health, 2010)

Such varied approaches reflect the best qualities of action research and constitute evidence-based practices that allow youth expertise to be the foundation for the promotion of mental health. In Montana, these approaches can draw the attention of decision-makers to yield positive benefits for Expanded School Mental Health.

Administrative Rule(s):
37.106.1956, which discusses services as clinically indicated to children or adolescents with serious emotional disturbance.

Model Application:
The Montana chapter of Youth MOVE works to tell individual mental health stories through the support of Youth MOVE's national organization. Members of the chapter create digital stories to tell their life journey with mental illness to increase the promotion of youths' needs around mental health. Youth from this chapter have spoken at the first Montana Mental Health Conference in 2009 and at the National Advancing School Mental Health Conference in Albuquerque, New Mexico, in October 2010. In both cases, the influence on mental-health decision makers is immeasurable. These stories and other digital stories help to change stigmas connected to individuals and families who live with mental illnesses.

Recommendations:
Administrative Rules could include the language of "promotion of mental health" as a means of integrating alternative supports to CSCT efforts. Since the intent of the Administrative Rules is

to guide the work of helping youth and families, adding language to support "youth engagement" could also increase the efficacy of CSCT teams.

6.8 Youth Leadership Opportunities

Providing youth leadership opportunities is part of the mental health continuum, a guideline of the National Community of Practice (IDEA Partnership, 2010). The National Community of Practice recognizes "Youth Leadership" as its own category of focus. Youth leadership empowers youth by building skills, creating environments of change, and engaging students at professional levels. In terms of mental health, youth leadership opportunities are not exclusive of students suffering from mental illness, and as a result, promote the ideas of integration and diversity.

Administrative Rule(s):

37.106.1960, which discusses program staffing and training AND
37.106.1956, which discusses program services.

Model Application:

One example of youth leadership opportunities in Montana is through the work of the National Coalition Building Institute (NCBI), based in Missoula. The NCBI strives to reduce stereotypes, negativity, and judgments by increasing awareness, acceptance, and respect of diversity through the "respect club curriculum." The "Respect Clubs" that stem from this program in middle schools repeatedly show that a school's cultural attitude toward negative behavior shifts within entire schools, not just among the students who participate (National Coalition Building Institute, 2010).

The NCBI's Web site states, "one-hundred percent of the youth involved in Respect Club in the 2007-08 academic year reported they felt more able to reduce violence in their schools as a result of the training" (Our work with youth and schools, 2010). An evaluation of Respect Clubs conducted by the U.S. Department of Education through the Safe and Drug-Free Schools Program concluded that "NCBI [is] an exemplary program," which "builds an internal campus capacity for moving beyond quick-fix responses to racial/gender tensions and instead fosters a school-wide climate that welcomes diversity" (National Coalition Building Institute, 2010). The NCBI leads two in-school workshops in Montana, "Violence prevention" and "Prejudice reduction," both of which can be tailored to grades 5-12.

Respect Clubs create leaders by virtue of their club structure, where graduates of these programs facilitate groups of earlier grades. Leaders are also sent to national trainings, wherein they gain the skills necessary to train peers in Montana. Respect Club Curriculums can be implemented by non-licensed professionals, such as those found in CSCT teams (Thurber, 2010).

Recommendations:

Administrative Rules could include the language of "youth leadership opportunities" as one way CSCT teams could more effectively work with all students, rather than just students with diagnosed SEDs. Since the Respect Club Curriculum can be implemented by a non-licensed CSCT team member, Administrative Rules could include a consideration of this praxis for groups, in concert with current Rules structure.

6.9 Training

Nationwide, training effectiveness is the least researched field in School Mental Health. Wandersman (2010) argues that trainings can be difficult because participants come with varied skills and individual needs, and no one training can take care of these individual needs, contributing to the continued gap between research and practice (Advancing School Mental Health Conference). This is why leaders in the field of SMH suggest the work of professionals needs to go beyond training and toward ongoing coaching and technical assistance (Weist, Personal communication, 2010). Implementing these follow-up components of training, the change from research to practice will continue increasing the likelihood of performance.

Administrative Rule(s):

Administrative Rule 37.106.1960, which discusses staffing and training for both licensed and non-licensed CSCT workers.

Model Application:

In November 2010, the University of Montana Institute for Educational Research and Service (IERS) hosted a meeting to discuss adequate training for professionals. This meeting consisted of representatives from multiple university departments and state representatives from CSCT, OPI and DPHHS, and discussed the formation of a cross-listed course to be offered at the University of Montana on the topic of School Mental Health, including multi-disciplinary approaches among Social Work, Counseling, and Psychology. This course could become a national model, owing to the absence of such a curriculum at the university level, and could contribute to the SMH field in terms of training and the research on training.

Recommendations:

Administrative Rules could expand and strengthen the language of training to ensure CSCT teams are getting the best use of trainings. The lack of thorough evaluation in CSCT team training affects the quality and amount of training CSCT teams receive. While particular training may be assumed, Rules could hold CSCT providers more accountable by separating the type of trainings that the "Therapist" and "Behavioral Aide" positions receive. Training requirements in the current Administrative Rules do not support that a licensed Therapist should have professional training requirements that are different from a Behavioral Aide position, nor is ongoing skill-development for the licensed Therapist stipulated.

Section VII: Positive Behavioral Intervention and Supports

Nationally, the Positive Behavioral Intervention and Supports (PBIS) model is gaining recognition as an effective way to integrate and complement mental health within school systems. The PBIS is a "decision-making framework that guides selection, integration, and implementation of the best evidence-based academic and behavioral practices for improving important academic and behavior outcomes for all students" (OSEP Technical Assistance Center, 2010).

Montana's PBIS adaptation is called Montana's Behavioral Initiative (MBI), modeled after the national Positive Behavioral Intervention and Supports (PBIS). **Figure 14** shows the four elements of MBI/PBIS.

Outcomes	Practices	Data	Systems
Academic and behavioral targets that are endorsed and emphasized by students, families, and educators	Curricula, instruction, interventions, and strategies that are evidence-based	Information that is used to identify status, need for change, and effects of interventions	Supports that are needed to enable the accurate and durable implementation of the practices of MBI/PBIS

Figure 14: Elements of Montana Behavioral Initiative/Positive Behavioral Intervention and Supports

The four elements of MBI/PBIS are directly affiliated with Expanded School Mental Health research; each element is an evidence-based practice that utilizes a current framework in school systems already implementing MBI/PBIS. One CSCT supervisor suggests that the increase of MBI schools might result in more effective School Mental Health treatment (Hughes, 2010). Multiple anonymous conversations by the author with CSCT workers have indicated that working in MBI schools furnishes the best environment for overall SMH integration.

The PBIS is designed to work within a three-tier prevention logic. This structure requires that all students receive support at the universal or primary tier. When behaviors at the primary level are not responsive, additional behavioral supports are provided at the secondary prevention tier. For individuals with more intensive service needs, the third or tertiary prevention tier is engaged. **Figure 15** shows the three-tiered prevention logic model and its relationship to CSCT, as shown in the percentage of students served.

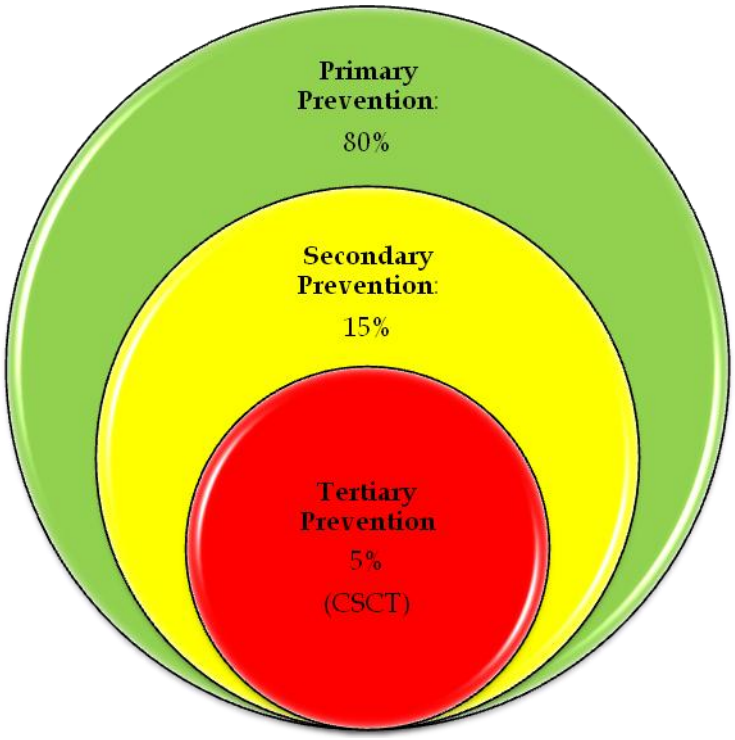

Figure 15: Positive Behavioral Support Prevention Logic (Montana Office of Public Instruction, 2006)

According to the national PBIS technical assistance center, a collaboration between the U.S. Department of Education and eleven technical assistance centers across the United States,

> Schools that establish systems with the capacity to implement SWPBS [school-wide PBIS] with integrity and durability have teaching and learning environments that are: less reactive, aversive, dangerous, and exclusionary; more engaging, responsive, preventive, and productive; address classroom management and disciplinary issues (e.g., attendance, tardiness, antisocial behavior); improve supports for students whose behaviors require more specialized assistance (e.g., emotional and behavioral disorders, mental health); most importantly, maximize academic engagement and achievement for all students. (What is school-wide Positive Behavioral Interventions & Supports?, 2010)

Such PBIS supports are parallel with traditional SMH approaches, but focus on the joint efforts of all professional disciplines involved with treatment.

The PBIS and MBI are supported through Montana's statewide public school system, the Montana Office of Public Instruction (OPI). The MBI is optionally available to every Montana public school. The PBIS is nationally recognized, data-driven, well-researched, and gaining attention at the federal policy level. According to MBI consultants in Montana, PBIS lays a foundational language for school teachers who do not often receive mental health training in their higher education training, but who recognize the need for additional help in their classrooms due to the increasing number of students receiving out-of-classroom services (Hughes, 2010).

Eber, Barrett, and Weist (2009) discuss the "the old approach" of SMH used by school districts (p. 4). **Figure 16** shows the "old approach" versus "new approach" of SMH following the PBIS framework:

"Old Approach"	"New Approach"
Each school works out their own plan for involving community mental health (MH) staff	District has a plan shaped by diverse stakeholders for promotion of learning, positive behavior and mental health for students, and a "shared agenda" is real in individual schools, with staff from education, mental health and other child serving systems working closely together and with youth and families for developing and continuously improving programs and services at all 3 tiers, based on community data as well as school data
One community MH clinician is housed in a school building 1 day a week to "see" students	There is "symmetry" in leadership among staff from education and mental health systems in leading and facilitating activities at all three tiers
The clinician does not participate in school teams and operates in relative isolation	Personnel from MH agency assists school district clinicians with facilitating some Tier 2 and Tier 3 interventions including some small group interventions, function-based behavior plans and wraparound teams/plans
No data are used to decide on or to monitor interventions	No new approach
There is no systematic evaluation, instead "intuitive" monitoring of efforts	No new approach

Figure 16: Traditional Approaches to SMH and PBIS Approaches to SMH (Barrett, Eber, & Weist, 2009)

Administrative Rule(s):
37.106.1956, which discusses program services AND
37.106.1960, which discusses program staffing and training

Model Application:
The Bitterroot Valley Education Cooperative, the only education cooperative licensed mental health center in Montana, is an example of collaboration between CSCT and MBI schools. All the schools the Bitterroot Co-op works with are MBI schools. The CSCT teams recognize the advantage of working with MBI schools because of the increased attention to behavior, data collection, evaluation of services, and team collaboration. The MBI schools commit to: 1) attend yearly trainings; and 2) participate in the MBI Summer Institute with school teams (Bitterroot Valley Education Cooperative, 2010).

Recommendations:
One way to increase the MBI/PBIS collaboration could be to require that CSCT workers become part of an MBI team when CSCT teams work in MBI schools. In addition, making the MBI trainings and summer MBI institute available for CSCT teams would be another way to increase the accessibility and relationships between CSCT and schools. Language incorporating these trainings and collaborations could be added to Administrative Rules, including provisions for the cost-sharing of trainings.

Section VIII: National Assembly on School-Based Health Care

The National Assembly on School-Based Health Care (NASBHC), a technical assistance center in Washington,D.C., employs seven principles that correlate with the principles of Expanded School Mental Health, as proposed by the author. **Figure 17** outlines NASBHC's principles, defining the role of a School-Based Health Center (SBHC), or those providers of "primary care, mental health services, and sometimes oral health care to students" (SouthEast Education Network, 2010).

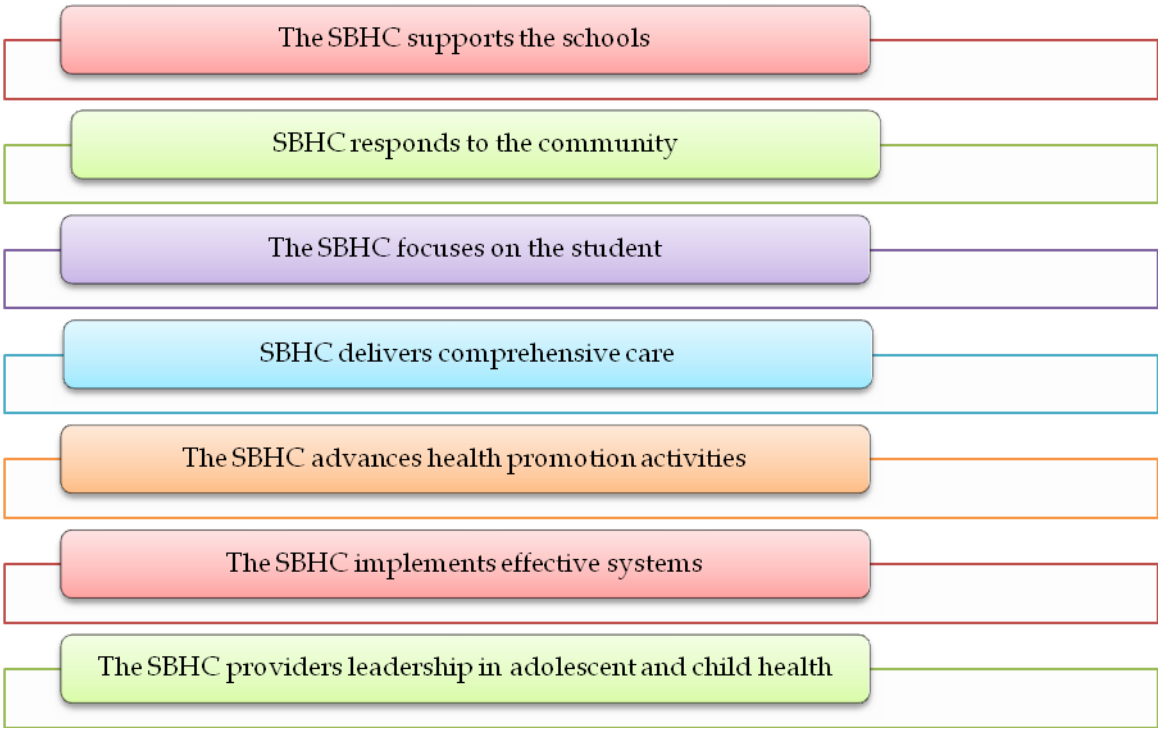

Figure 17: Principles of National Assembly on School-Based Health Care (National Assembly on School-Based Health Care, 2010)

These principles "provide guidelines by which to benchmark programs, define the essential elements of a School-Based Health Center, and provide a framework for accountability and continuous improvement" (National Assembly on School-Based Health Care, 2010).

Most SBHCs are funded through a diverse set of sources, including federal, state, and public sector grants, patient revenue, private/corporate support, and through in-kind contributions from school and community agency partners (National Assembly on School-Based Health Care, 2010). One national survey of SBHCs (2007) indicates that 80 percent of SBHCs bill student health insurance. Research demonstrates that SBHCs are shown to provide ongoing evaluation of their services and "increase children's access to health care." Research also demonstrates that SBHCs decrease absenteeism and tardiness among adolescents who received counseling services in a SBHC (School-Based Health Centers improving health care access and student success). Additional information on research, evaluation, and cost-benefits of SBHC appears in **Appendix III**: School-Based Health Centers Improving Health Care Access & Student Success.

School-Based Health Centers have received much attention and show such successful results in their work to the extent that the federal government is recognizing the importance of health centers in schools. In 2010, the Health Resources and Service Administration (HRSA) promoted the Affordable Care Act (ACA) Grants for School-Based Health Centers Capital (SBHCC) Program, making funds available for Health Centers on school campuses (National Assembly on School-Based Health Care, 2010).

Model Application:
West Virginia was chosen by NASBHC as a pilot state for the center's Capacity Building Training Initiative, which expanded quality School Mental Health services for their state. This initiative brought together Bureaus of Behavioral Health and Public Health, in addition to technical assistance centers at Marshall University and other professional programs. West Virginia has been able to forward the progress of statewide mental health as a result of these partnerships (W.Va. chosen for national pilot school mental health project, 2009).

Administrative Rule(s):
37.86.2225, which discusses program billing AND
37.106.1902, which discusses mental health center definitions AND
37.106.1956, which discusses services AND
37.106.1960, which discusses staffing and training AND
37.106.1961, which discusses client record requirements.

Recommendations:
Due to the large number of states implementing SBHCs, the Office of Public Instruction and the Department of Health and Human Services may consider more research for application of these models in Montana. In addition, looking at the funding possibilities for the 2011 grant cycle would give Montana time to do additional research and build relationships with schools and communities that may consider supporting a pilot health center. Possible partnerships might include: public health centers, hospitals, Indian Health Services and the Bureau of Indian Affairs, in addition to schools and communities themselves.

The SBHCs incorporate existing mental health care services and CSCT could be a part of this health model. Instead of CSCT teams working chiefly in schools, CSCT providers could become part of a larger medical staff housed within School-Based Health Centers. Considering the entire well-being of a student reaches beyond what any one health profession is able to provide. An SBHC better allows for staff to assess health from a physical, emotional, and psychological perspective.

Language in the Administrative Rules could include a consideration of SBHCs, with a specific ARM dedicated to the services provided by CSCT teams AND other medical/health professionals located in School-Based Health Centers. Ohio and West Virginia examples of states that have progressed using this model. Both states have implemented a Mental Health Planning and Evaluation Template (MHPET), in collaboration with the National Assembly of School-Based Health Care. The MHPET is based on a 40-question school assessment, which catalogs strengths and gaps in mental health services. Schools in West Virginia have used the MHPET to monitor progress. In 2010, the state of West Virginia has required a pre- and post-school year MHPET for all planning sites in an attempt to increase efficacy and collaboration (National Assembly on School-Based Health Care, 2010).

Section IX: General Recommendations for the Process of Administrative Rule Changes

Recommendation One: *Include Stakeholders*

(Involve multiple stakeholders in CSCT Administrative Rule change process.)

It is recommended that the Department of Public Health and Human Services and the Office of Public Instruction include representation from the following in the Rule change process:

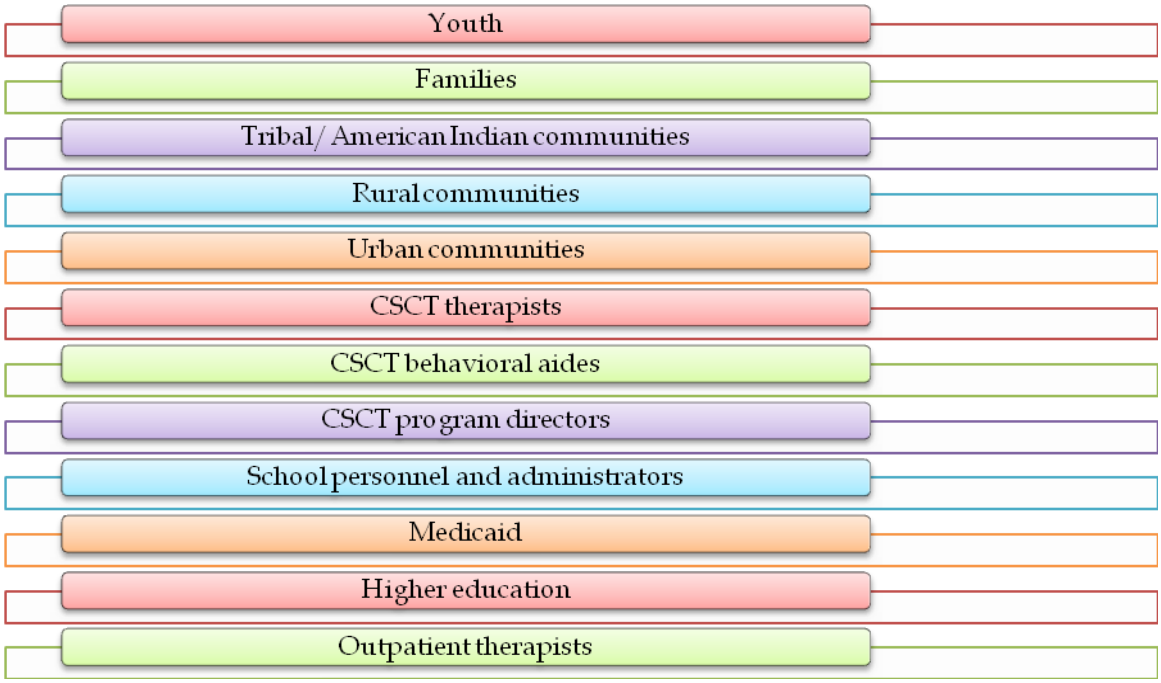

Figure 18: Proposed Stakeholders in Administrative Rule Revision Process

Section IX: General Recommendations for the Process of Administrative Rule Changes

Recommendation Two: *Continue with Evaluation and Assessment of CSCT*
(Conduct a thorough evaluation of the Comprehensive School and Community Treatment (CSCT) by implementing a Quality Assessment and Improvement analysis.)

A continued thorough evaluation of CSCT would help Montana perceive gaps in current Administrative Rules and offer an opportunity to include stakeholders. Such an evaluation should be done through quantitative and qualitative research methodologies (see **Section 6.5** Outcomes and Evaluation). Evaluation could also incorporate Community-University (C-U) partnerships (see **Section 6.5** Outcomes and Evaluation). Through such partnerships, an evaluation process could be developed in a graduate research course and result in hands-on graduate and/or Ph.D student work.

More so, a statewide evaluation of CSCT could be an effective use of national contacts and partnerships. The state should also advise with technical assistance centers, as found in **Appendix IV**: National Contacts.

Section IX: General Recommendations for the Process of Administrative Rule Changes

Recommendation Three: *Increase the Use of Technology*

(Increase the use of technology for therapeutic services, professional development, and statewide collaboration.)

Regardless of how effective building partnerships and meeting face-to-face can be, technology in the 21st century allows for powerful connection. Nationally, technology is being used to provide services from training to therapy. Technology is a wonderful way to increase knowledge and connection across Montana, such as in the case of webinars. Webinars can allow for interaction and offer the opportunity to bring in national presenters on specific topics without the cost of travel and other face-to-face consulting expenses. Though many areas throughout Montana are physically isolated from larger communities, technology allows for new possibilities.

Technology can also be used for therapeutic purposes. The state of Hawaii is a national leader in their work around telepsychiatry services. Hawaii finds telepsychiatry to be one strategy psychiatrists are able to work with and provide quality services to students and families in some of the most rural islands. In addition, Hawaii has a speech and language pathologist providing services through teleconferencing. Those providing teleservices do travel to the islands to meet clients in person on a limited basis (Stern, 2010).

Researchers in Hawaii propose that "telepsychiatry is a superior way to provide efficient, high-quality and logistically sustainable psychiatry services to students" (Roth & Zekovic-Roth, 2010, p. 2). Roth and Zekovic-Roth found telepsychiatry implementation demonstrates no changes in diagnosis and treatment outcomes of numerous mental illnesses, including PTSD and depression, though better results are found when treating "children and adolescents with ADHD, children and adolescents with autism spectrum disorders," and is "especially helpful in treatment of abuse victims when the clear physical separation can actually facilitate the formation of a therapeutic alliance" (2010, p. 2).

Section IX: General Recommendations for the Process of Administrative Rule Changes

Recommendation Four: *Work Collectively*

(All nine CSCT providers begin working collectively to come up with a shared agenda and shared goals.)

In an article published in *International Journal of Mental Health Promotion* (2002), researchers argue the importance of professional organization, policy leaders, and families to develop a shared agenda. They write, "experience has shown that much of the misunderstanding and discord that occurs among different child-serving agencies arises from erroneous assumptions and beliefs about the mission and goals of the other agencies, and the legal and funding mandates that help drive an agency's agenda in meeting the needs of the children and young people" (Andis, et al., p. 30). The authors continue to point out that family and youth organizations, public education, and state mental health systems simultaneously share key values and goals. "All want every child and young person to become a healthy, productive and caring citizen. All want safe and effective schools, homes, and communities. All acknowledge the need to improve positive family participation and cultural responsiveness to families" (Andis, et al., 2002, p. 30).

Dr. Julie Owens, Associate Professor at Ohio University and leader in the development of the Ohio registry, suggests one strategy for CSCT programs to build consistency - all nine CSCT providers begin coming up with a vision of what CSCT programs would like to include their shared agenda and shared goals, thinking about what indicators of those goals would look like (Owens, Personal communication, 2010). Policy-makers and family organizations can develop and embrace a shared agenda in partnership, with a "common conceptual framework that can underpin a comprehensive approach to mental health services in schools: a seamless, fluid, interlinked multi-level framework that encompasses positive child and youth development, prevention, early intervention, and intensive interventions" (Andis, et al., 2002, p. 31).

Montana families, youth organizations, schools, state government, and CSCT providers no doubt want the most positive outcomes for families and youth. The ability to bring these entities together to close the gap and develop frameworks is time intensive, but too critical not to address in system-wide changes.

Section X: General Recommendations for Funding CSCT Programs

Recommendation One: *Implement Additional Funding Sources*

(Comprehensive School and Community Treatment (CSCT) providers, schools, and communities implement additional funding opportunities outside of Medicaid to broaden School Mental Health.)

If a percentage of CSCT budgets were mandated to be funded from additional sources other than Medicaid, doors could open for the availability of CSCT teams to work with a child or youth from any financial background and, thereby, any youth in need. Alternative funding opportunities could come from a number of sources, including those in **Section VIII**: National Assembly on School-Based Health Care. Expanding funding requirements could allow CSCT teams a great deal of professional flexibility, most importantly the ability to work with any student in need.

Diagnosing is an ethical process for mental health professionals across the nation. By having a SMH health system set up to provide services only to those required by a specific deficit criteria may put CSCT therapist in an ethical bind, especially if this becomes the criteria for students in need to receive services. Though CSCT workers do not provide medications for patients, the caution of diagnosing is important to take into consideration. Availing the possibilities for CSCT teams to work with all students is imperative for youth, families, and communities. Without a clear cost-sharing expectation outlined in Administrative Rules, youth are declined treatment on the merit of Medicaid, not need.

Section X: General Recommendations for Funding CSCT Programs

Recommendation Two: *Apply for Grant Funding*

(Reapply for the Integration of Schools and Mental Health Systems Grant.)

Nationally, many states have been able to forward School Mental Health through the support and funding of the Integration of Schools and Mental Health Systems Grant. This grant is intended to:

> Provide funds to improve students' access to mental health services by creating innovative linkages between school, mental health and juvenile justice systems. Projects funded under this program support infrastructure development to develop and/or improve collaborative efforts between schools, mental health service systems and juvenile justice systems to provide, enhance, or improve prevention, diagnosis, and treatment services to students; enhance crisis intervention services; provide professional training, provide technical assistance to systems and families; ensure linguistically appropriate and culturally competent services; and evaluate the effectiveness of the program. (U.S. Department of Education, 2010, p. 2)

Grant information can be found online at: www.ed.gov/programs/mentalhealth. In 2010, the grant submission deadline was February 22 and the average fiscal award: $347,800.

Bibliography

American Evaluation Association. (2010, November 2). *About us*. Retrieved November 2, 2010, from American Evaluation Association: www.eval.org

Andis, P., Cashman, J., Oglesby, D., Praschil, R., Adelman, H., Taylor, L., et al. (2002). A strategic and shared agenda to advance mental health in schools through family and system partnerships. *International Jounral of Mental Health Promotion*, 28-35.

Barrett, S., Eber, L., & Weist, M. (2009, November). Development of interconnected systems framework for school mental health. *Concept paper*. Columbia, Missouri, USA: Center for School Mental Health.

Bitterroot Valley Education Cooperative (2010). *Home*. Retrieved August 21, 2010, from Bitterroot Valley Education Cooperative: bvec-mt.org

Bronstein, L. R. (2003). A model for interdisciplinary collaboration. *Social Work*, 297-306.

Bruns, E. J., Walker, J. S., Zabel, M., Matarese, M., Estep, K., Harburger, D., et al. (2010). Intervening in the lives of youth with complex behaviorial health challenges and their families: the role of the Wraparound process. *American Journal of Community Psychology*, 314-331.

Caringi, J. (2010, October). Secondary traumatic stress. Missoula, MT.

Center for School Mental Health. (2009, March 4). *Quality Assessment and Improvment*. Retrieved October 1, 2010, from Center for School Mental Health, University of Maryland School of Medicine: http://csmh.umaryland.edu/research/qualityassessment.html

Clay, R. A. (2009, September). Achieving better outcomes. *Monitor on Psychology*, pp. 47-48.

Clouder, L., & Sellars, J. (2004). Reflective practice in clinical supervision: an interprofessional perspective. *Issues and Innovations in Nursing Practice*, 262-269.

Evans, S. W., & Weist, M. D. (2004). Implementing empirically supported treatments in the schools: What are we asking? *Clinical Child and Family Psychology Review*, 263-267.

Evans, S. W., Weist, M. D., & Serpell, Z. (2007). Quality and School Mental Health. In M. Weist, S. Stephen, N. Lever, E. Moore, & P. Flashpolher, *Advances in school-based mental health interventions* (pp. 1-20). New York: Civic Research Institute.

Flaspohler, P. D., Anderson-Butcher, D., Paternite, C. E., Weist, M., & Wandersman, A. (2006). Community science and expanded school mental health: Bridging the research-to-practice gap to promote child well-being and academic success. *Educational & Child Psychology*, 27-41.

Gillispie, K. (2010, July 23). Personal communication. (E. Butts, Interviewer)

Hughes, C. (2010, October 6). Personal Communication. (E. Butts, Interviewer)

IDEA Partnership (2010). *Communities of Practice*. Retrieved October 15, 2010, from Idea Partnership: www.ideapartnership.org

Illinois Children's Mental Health Partnership (2005, June 30). Strategic plan for building a comprehensive children's mental health system in Illinois. Chicago, Illinois: State of Illinois.

Kutash, K., Duchnowski, A., & Lynn, N. (2006). *School-based mental health: An empirical guide for decision-makers*. Tampa, FL: The Louis de la Parte Florida Mental Health Institute.

McNiff, J., & Whitehead, J. (2010). *You and your action research project.* New York: Routledge.

Mears, S. L., Yaffe, J., & Harris, N. J. (2009). Evaluation of Wraparound services for severely emotionally disturbed youth. *Research on Social Work Practice*, 678-685.

Milne, D. L., & James, I. A. (2002). The observed impact of training on competence in clinical supervision. *British Jounral of Clinical Psychology*, 55-72.

Montana Department of Public Health and Human Services (2003). *School-based services: Medicaid and other medical assistance programs.* Helena, MT: Montana Department of Public Health and Human Services.

Montana Office of Public Instruction (2006, Februrary). *Coaches corner.* Retrieved July 28,

2010, from Montana Office of Public Instruction: opi.mt.gov

Montana Office of Public Instruction (2010, September). CSCT provider sites. Helena, MT: Montana Office of Public Instruction.

Montana Office of Public Instruction (2009). *Facts about Montana education.* Helena, MT: Montana Office of Public Instruction.

National Assembly on School-Based Health Care. (2010). CSMH 15th annual conference on advancing school mental health. *Building statewide and school district capacity in school mental health.* Albequerque, NM: National Assembly on School-Based Health Care.

National Assembly on School-Based Health Care (2010). *NASBHC principles & goals for school-based health centers*. Retrieved August 18, 2010, from National assembly of school-based health care: www.nasbhc.org

National Assembly on School-Based Health Care (2007). *School-Based Health Centers improving health care access and student success.* Retrieved August 15, 2010, from National Assembly for School-Based Health Care: www.nasbhc.org

National Assembly on School-Based Health Care. (2009, March). *W.VA. chosen for national pilot school mental health project.* Retrieved October 15, 2010, from National Assembly on School-Based Health Care: www.nasbhc.org

National Coalition Building Institute (2010, October 13). *Our work with youth and schools*. Retrieved October 13, 2010, from NCBI Missoula: www.ncbimissoula.org

National Federation of Families for Children's Mental Health (2010, November 25). *Welcome to Youth MOVE national*. Retrieved October 10, 2010, from Youth MOVE National: www.youthmovenational.org

Nierson, K. (2010, July 19). Director, Missoula County School District Special Education. (E. Butts, Interviewer)

OSEP Technical Assistance Center (2010, March). *Is school-wide positive behavior support an evidence-based practice.* Retrieved September 27, 2010, from Positive Behaviorial Interventions & Supports: www.pbis.org

OSEP Technical Assistance Center (2010, September 15). *What is school-wide Positive Behavioral Interventions & Supports?* Retrieved September 2010, from Positive behavioral interventions and supports: www.pbis.org

Owens, J. (2010, September 21). Personal communication. (E. Butts, Interviewer)

Owens, J., Dan, M., Alvarez, H., Tener, D., & Oberlin, K. (2007). *Using community-university partnerships to advance school mental health programming: Why, what & how?* Athens: Ohio Effective Practice Integration Council.

Paternite, C. E. (2010). *Quality and effective practice registry*. Retrieved September 20, 2010, from Ohio Mental Health Network for School Success: www.units.muhohio.edu/csbmhp

Roth, D. E., & Zekovic-Roth, S. (2010, May 25). Evidenced-based proposal for the effective delivery of psychiatric services to students in Maui County public schools via telepsychiatry. Honolulu, HI: Mind & Body Works Inc.

SouthEast Education Network (2010, March 31). *School-based healthcare: Why it is common sense*. Retrieved November 20, 2010, from SouthEast Education Network: www.seenmagazine.us

Stern, K. (2010, September 8). Personal communication. (E. Butts, Interviewer)

Thurber, A. (2010, November 12). Personal communication. (E. Butts, Interviewer)

U.S. Department of Education (2010, February 23). *Grants for the integration of schools and mental health systems.* Retrieved November 3, 2010, from U.S. Department of Education: www.2.ed.gov/programs

U.S. Department of Health and Human Services (1999). *Mental health: A report of the surgeon general - Executive summary.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Insitutes of Health, National Institue of Mental Health.

Vandenberg, J., & Haws, C. (2010, September). High fidelity wraparound. Helena, Montana: Vroon Vandenberg LLC.

Wandersman, A. (2010, October 5). Advancing School Mental Health Conference. (E. Butts, Interviewer)

Wandersman, A. (2003). Community science: Bridging the gap between science and practice

with community-centered models. *American Jounral of Community Psychology* , 227-242.

Wandersman, A., Imma, P., Chinman, M., & Kaftarian, S. (2000). Getting to outcomes: a results-based approach to accountability. *Evaluation and Program Planning* , 389-395.

Weist, M. (2006). "NASBHC Power Point." Baltimore, Maryland.

Weist, M. (2010, October 6). Personal communication. (E. Butts, Interviewer)

Appendix I: State of West Virginia School Mental Health Contract

Sample Working Agreement

PARTNERSHIP BETWEEN _____SCHOOL AND
_____COMMUNITY AGENCY
FOR PROVISION OF BEHAVIORAL HEALTH SERVICES

The language below is intended to be as comprehensive as possible. Language should be tailored to the needs and requirements of each institution. It is not necessary to include all the sections below.

1. MISSION

The mission of this School-Community Partnership is to create a safe and supportive environment for students at_____ School. This mission supports the mission of the school to create an environment of lifelong learners who achieve their maximum potential to participate and contribute to a democratic society.

2. STATEMENT OF NEED/PURPOSE OF AGREEMENT

In response to _____
_____, the _____ School, with the help of its Collaborative Stakeholder Group, conducted a needs assessment of its students. The results of this assessment indicated a high number of students reporting signs of mental health/substance use problems, substance abuse and exposure to violence. In tandem with the needs assessment, the Collaborative Stakeholder Group conducted an asset mapping survey to assess what services and supports are available to the students in their school environment. The results of this survey indicated an insufficient number of staff to address students presenting with mental health problems, as well as a lack of information and inadequate knowledge about how to intervene with the reported problems. In response to the high degree of mental health needs of students and staff limitations in addressing those needs, the _____ School and the _____ _____Community Agency have cooperatively designed a program that provides prevention, early intervention and treatment services to the students of the _____ School.

During a 2-year period, objectives, which must be measurable, are:

1) Increase students' and staff knowledge of social and emotional development, mental health and substance use.
2) Decrease reported incidents of violence, substance abuse, suspensions, and absences.
3) Increase number of mental health referrals made by school personnel.
4) Increase percentage of students accessing and receiving mental health/substance use services.

3. RELATIONSHIP BETWEEN PARTIES

THIS AGREEMENT is made as of this ___ day of _____, 20___ by and between the _____ School hereinafter referred to as the "School," and the _____ Agency, hereinafter referred to as "Consultant." The term of the contract will be effective _____and reviewed yearly. At any time, the School or Consultant may terminate this contract with a 30 days prior written notice without incurring any liability. The School and Consultant acknowledge that for the purposes of services rendered pursuant to this Contract that the Consultant is an independent contractor and neither the Consultant nor any of the Consultant's employees is an employee of the School. Consultant must give full personal attention to the faithful execution of this Agreement. Consultant shall not subcontract or assign any part of the Agreement without written consent of the School.

4. CONTACT INFORMATION OF BOTH PARTIES
All written notices and communications concerning this Agreement should be sent by the School to the Consultant and shall be addressed to:

_____
(Include name, title, and mailing address)

All written notices and communications concerning this Agreement should be sent by the Consultant to the School and shall be addressed to:

_____
(Include name, title, and mailing address)

5. EXPECTATIONS OF BOTH PARTIES
Description of Services
In support of our mission to create a safe and supportive environment for students at the _____ School, we agree to support the School-Community Partnership in the following ways:

The School will:
• Maintain continued membership and active participation in the School-Community Partnership.
• Provide administration and fiscal oversight for the project.
• Be responsible for hiring the Project Coordinator and monitoring the entire project.
• Provide facility space for contracted providers for the delivery of program services and activities.
• Promote program services and activities in the community.
• Maintain ongoing, consistent communication between the School and Consultant.
• Provide data necessary for evaluation of this proposal to the local evaluator(s).

• Follow established protocols for referral, crisis and treatment protocols that specify procedures for: a) Who refers, b) How and to whom to refer (phone/written), c) When to refer, for what reasons, d) What action is taken with the referral, e) How are communications and feedback handled regarding referral.

The Consultant will:
• Maintain continued membership and active participation in the School-Community Partnership.
• Assure the provision of consultation, education, screening, assessing, referring, treatment and coordination of services for youth in need of mental health services (on-site and off-site).
• Collaborate with the school and other project partners to ensure the linkage and delivery of services that respond to the family's needs. (Includes, but is not limited to: social services, mental and physical health assessment, and mental health services.)
• In compliance with mental health confidentiality law and HIPAA regulations, provide data necessary for evaluation of this proposal to the local evaluator(s).
• Follow established referral, crisis and treatment protocols that specify procedures for: a) Who refers, b) How and to whom to refer (phone/written), c) When to refer, for what reasons, d) What action is taken with the referral, e) How communications and feedback are handled regarding referral.
• Collaborate with school to tailor classroom observation, skill training, school-wide interventions and prevention activities (e.g., social and emotional development, educational information about risk and protective factors for mental health, substance abuse and violence prevention).

Expected Outcomes:
• Consultant will provide ____ FTE in the school.
• Consultant will provide a minimum of ____consultations to school staff on mental health, substance use, and social and emotional development.
• Consultant will serve at a minimum of ____students.
• Absentee rate will decrease by ____percent.
• Suspension rate will decrease by ____ percent.
• Reported incidents of violence will decrease by ____ percent.
• Reported incidents of substance abuse will decrease by ____percent.

6. COMMUNICATION AND COORDINATION
The Project Coordinator for the SCP will be responsible for coordinating communication and information sharing among participating partners. Methods for sharing information will include quarterly meetings of the Collaborative Stakeholder Group, written status reports, and monthly meetings between the Project Coordinator and the Principal or Principal's designee.

7. CONFIDENTIALITY

The Contractor agrees that any information obtained concerning persons served by the agency will remain confidential.
The Contractor agrees not to disclose any information concerning said persons without written authorization from said persons, and only for purposes directly connected with the administration of the program and services, or as may be required by state or federal law: HIPAA; FERPA; Mental Health and Developmental Disabilities Confidentiality Act; mandated abuse and neglect reporting.

Written release of information and/or disclosure of records. Contractor shall request authorization in writing from the minor and his/her parent or guardian to release any information to the school, including assessment, treatment planning, and discharge summary.

Guidelines

8. MONITORING AND EVALUATION
The Collaborative Stakeholder Group will evaluate the implementation of the Agreement annually. The School and Consultant will develop criteria based on expected outcomes to evaluate the implementation of the Agreement using existing review data and monitoring procedures of each agency.

ACTIVITIES MAY INCLUDE:
1. Training and Technical Assistance. The Collaborative Stakeholder Group will assess training and technical assistance needs related to collaboration and service coordination for the target population. During quarterly meeting of designated agencies, training and technical assistance needs will be discussed and strategies for collaborative support and assistance will be developed.
2. Performance Evaluation. The School or Collaborative Stakeholder Group may conduct an evaluation for the Consultant's performance under this Agreement. Consultant shall fully cooperate with the School and shall provide such information and documents as may be requested to conduct the performance evaluation.
3. Quality Management. The School and Consultant must follow the procedures set in place by the Collaborative Stakeholder Group to resolve disputes between agency and school staff.
4. Consumer Rights. Each student must be treated with dignity and afforded full rights as an individual to make decisions and participate in treatment planning. There shall be a written complaint/grievance process, visible to students, through which a student may appeal a dispute with the Agency.

9. TARGET POPULATION
The program will target high school-age children who attend the _____ School with three levels of interventions:

1. General Education Population – Students who would benefit from participating in programs that promote social and emotional learning.
2. High-Risk Students – Students who have been identified by teachers or support staff as displaying behavioral and/or emotional problems and need to be assessed for possible services.
3. Students experiencing mental health problems – Students who have experienced a mental health crisis and/or history of mental illness who require short-term diagnostic and treatment services.

10. ENVIRONMENT
Services will be provided in the school building. The school is expected to provide the Agency with a mailbox, a workspace that permits confidential interviews and access to a phone for confidential calls. The workspace will be made available to the agency on ___ (day of week) during the hours of _____. When school is closed for vacation or holidays, the agency can access the space by submitting a written request to _____. The school and school's respective custodial contractor will clean and maintain the space with the baseline regulations established for the entire building.

11. RECORD KEEPING/DOCUMENTATION
Records. The Consultant will keep working files for each student in a locked cabinet in the designated office, which can also be locked. As cases are closed, files will be transported to the Agency and kept in a secure space. Policies regarding access and maintenance of records, including electronic records, will be developed and followed by the partnership.

Reporting. On a quarterly basis, the Consultant agrees to submit documentation identifying the number of students referred, the number of assessments made, and the number of students receiving services. A summary of program activities for the school year will be submitted annually by ____(date), and will include: demographic information on each child receiving services, a summary of the activities of the Consultant, and a summary of evaluations completed by the school principal and members of the Collaborative Stakeholder Group.

12. ROLES AND QUALIFICATIONS OF STAFF
Professional Licensure and Certification. In the event that the services to be provided by the Consultant must by law be provided by individuals who are licensed and/or certified, the Consultant shall only assign individuals to provide services under this Agreement who are licensed, certified, and/or credentialed in accordance with the law. All such individuals assigned by the Consultant to provide services shall maintain their license and/or certification in good standing during the term of this Agreement. Consultant shall, prior to providing services, submit documentation that the individuals assigned to provide services are properly credentialed and are licensed and/or certified to: _____.

Criminal Background Check. It is the responsibility of the Consultant to make certain that its employees, agents, volunteers and contractors who may have contact with students are in compliance with the School Code of West Virginia.

13. INSURANCE
The Consultant shall maintain current insurance coverage for itself and each staff who provides services pursuant to the Agreement in an amount satisfactory to the School. Such coverage shall include professional liability, malpractice, worker's compensation and bonding. Before any services are provided hereunder and upon execution of this Agreement, contractor shall furnish the school certificates for coverage.

Indemnification. Contractor hereby agrees to indemnify and hold harmless the School, its officers, agents and employees against any and all claims, directly or indirectly arising out of or relating or resulting from the furnishing of services described herein, and caused by negligence of Consultant or its staff.

14. PAYMENT, COSTS AND BILLING MECHANISMS

OPTIONS MAY INCLUDE:
1. Billing Medicaid. The School agrees that the Consultant shall be responsible for billing Medicaid and other third party payers for the Consultant's services rendered hereunder. Consultant reserves right to keep any such payment collected.
2. Costs for Services. In return for services provided by the Consultant, the School will reimburse for services provided in accordance with the attached budgets upon completion of any and all require documentation (e.g., evaluation reports, time sheets, logs, receipts). Payment will be made monthly (or in aggregate amount) not to exceed $xx. This amount may be increased to $xx pending review by Project Coordinator.
3. Submission of Invoices. All invoices for services need to be turned in on a monthly basis with a description of services, the number of hours, social security numbers of clients, and the cost for each service. The parties agree that the Consultant invoices are to be submitted to the School in a timely manner, after the services have been provided to the School. If invoices are submitted after six months after the last date the services have been rendered, then the School shall have no obligation to pay for the stale invoices.
4. Taxes. The Consultant is responsible for complying with all federal and state laws as to tax and Social Security payments to be withheld from wages paid to said employees. The school assumes no responsibility for the payment of any compensation, wages, benefits, or taxes by, or on behalf of, the Consultant, its employees and/or others by reason of this Agreement.

15. NONDISCRIMINATION

The Consultant agrees to comply with ADA, Americans with Disabilities Act, Title VI of the Civil Rights Act of 1964, the Constitution of the United States, and any laws, regulations or orders, state or federal, which prohibit discrimination on the grounds of race, sex, religion, national origin, inability to speak or comprehend the English language, or by reason of disability.

16. LIABILITY
The School assumes no liability for actions of the Consultant under this Contract. The Consultant agrees to hold harmless, the School, against any and all liability loss, damage, cost or expenses arising from wrongful or negligent acts of the Consultant, which School may sustain, incur or be required to pay as a result of Contractor's performance under this contract.

17. SIGNATURE OF BOTH PARTIES

_____ _____
Agency Director Date of Signature

_____ _____
Authorized School Official Date of Signature

This sample working agreement was developed with input from the following documents:
1. Mental Health Association of the North Shore (MHANS) Community Partnering Program for Social-Emotional Wellness
2. Statewide Cooperative Agreement between U.S. Department of Health and Human Services Region V, IDCFS,IDHS, Illinois Head Start Association, August 2004
3. Chicago Public Schools Policy for School-Based Health Centers
4. Contract Agreement between Baltimore Mental Health Systems, Inc., and the University of Maryland, Baltimore School Mental Health Program
5. Contract between County Head Start/Early Head Start Program and County Mental Health Center
6. Contract for physical therapy, occupational therapy and speech/language/pathology services between the Rainbow Center and Naperville Community Unit School District
7. Contractual Agreement for Safe Schools/Healthy Students Partners, Fillmore Center for Human Services and Community Care Options and Morton School District
8. Contractual Agreement for Safe Schools/Healthy Students Partners, J. Sterling Morton High School District and Cook County Department of Public Health
9. Education Referral Protocol for Referrals to the Mental Health System of Care, Champaign County
10. Interagency Memorandum of Agreement between Illinois State Board of Education, Illinois Head Start, Administration for Children and Families, Illinois Department of Human Services, Mental Health
11 . Letter of Agreement between Community Counseling Centers of Chicago and Asian Human Services

12. Letter of Agreement between Community Counseling Centers of Chicago and Institute for Juvenile Research
13. Master Professional Services Agreement between the Baltimore City Board of School Commissioners and University of Maryland, Baltimore
14. Memorandum of Agreement for Safe Schools Healthy Students Initiative, We Go Together (West Chicago Elementary District #33 and collaborating agencies) Service Provision Protocol Agreement between Community Counseling Centers of Chicago and Chicago School Readiness Project
15. Skilled Nursing Service Agreement between Midwest Home Health Care and Naperville CUFD

Appendix II: Ohio Effective Practice Registry Application

Ohio's Registry of Effective Practice in School Success and Mental Health Programming
2008-2009 APPLICANT EVAUALTION PROCEDURES

Each registry application will be reviewed and evaluated by three members of the QEPAT (or OMHNSS)
The three evaluators will be selected using the following guidelines:
Each application will be reviewed by at least one network university partner
Each application will be reviewed by at least one network community partner
Each application will be reviewed by at least one graduate student
The reviewers comprising the three-person team will not be from the same network action region as the applicant
Evaluation ratings will be made through an on-line format provide by Miami University
Evaluation ratings will be compiled across the three reviewers. The QEPET will review these aggregated ratings in the following formats:
An average score will be created for each rating domain
The range of ratings for each domain will be created
Those programs that exceed the minimum threshold will be considered for future contact by one of the three evaluators. The minimum threshold is defined as
Meeting the minimum criteria for effectiveness
And demonstrating strengths in at least one of the first three rated dimensions (i.e., #1, #2, or #3), as evidenced by score of 4 or higher on a 7-point scale

2008-2009
OHIO EFFECTIVE PRACTICE REGISTRY APPLICANT EVALUATION FORM

EVALUATORS: BELOW EACH DIMENSION, WE HAVE PROVIDED CHARACTERISTICS TO CONSIDER AS YOU MAKE YOUR RATINGS. HOWEVER, PLEASE KEEP IN MIND THAT THE APPLICATION DOES NOT DIRECTLY ASK APPLICANTS TO ADDRESS ALL OF THESE AREAS. PLEASE MAKE YOUR BEST JUDGEMENT AND ALL RATINGS WILL BE DISCUSSED VIA PHONE CONFERENCE BEFORE MAKING ANY DECISIONS ABOUT THE APPLICANT'S SUITABILTY FOR THE NEXT STEP.

Date of Evaluation:

Region:

Role: ☐ University Partner ☐ Community Partner ☐ Graduate Student Reviewer
☐ Family Partner

Please rate the quality of the applicant/program on the following dimensions. If an applicant meets the minimum criterion for a given domain, you must provide a rating of 4 or above.

Does the applicant/program meet the minimum criteria for effectiveness? ☐ Yes ☐ No

1. Evidence of effectiveness

1----------2----------3----------4----------5----------6----------7
Weak Acceptable Excellent

When evaluating evidence of effectiveness, consider the following characteristics. Note: Different combinations of the following characteristics may lead to different ratings. Please also refer to these characteristics when providing feedback (either positive or constructive).

Applicant has data beyond testimonials, anecdotes, satisfaction surveys, and service unit counts
Applicant provides evidence of change that is related to the program objectives
Applicant has identified the tool that measures effectiveness (e.g., Rating Scales, GPA)
Applicant has effectiveness data at the individual student level
Stronger ratings may be given to applications that have more than one year of effectiveness data
Also, consider (a) the strength of the comparison group, (b) the timing of the outcome measurement (e.g., pre and post), and (c) the sample size
Does the applicant/program meet the minimum criteria for sustainability? ☐ Yes ☐ No

2. Strength of sustainability plan

1----------2----------3----------4----------5----------6----------7
Weak Acceptable Excellent

When evaluating evidence of sustainability, consider the following characteristics. Note: Different combinations of the following characteristics may lead to different ratings. Please also refer to these characteristics when providing feedback (either positive or constructive).

Applicant describes a consistent funding source or blended funding sources
Applicant describes evidence of committed resources by partners (financial, personnel, reallocated resources, development of infrastructure, evidence of system shifts)
Applicant describes dedicating time/resources to personnel training and/or capacity building
Applicant describes the history of the program in a way that demonstrates duration, longevity, and/or overcoming barriers
Applicant provides some evidence of creative use of funding or creativity toward sustainability

Does the applicant/program meet the minimum criteria for strength of partnership? ☐ Yes ☐ No

3. Strength of partnership with community members (e.g., parents, community agencies, universities)

1----------2----------3----------4----------5----------6----------7
Weak Acceptable Excellent

When evaluating the strength of the applicant's partnerships, consider the following characteristics. Note: Different combinations of the following characteristics may lead to different ratings. Please also refer to these characteristics when providing feedback (either positive or constructive).

History and duration of the partnership
Resilience to change (turnover, funding changes)
Growth of the partnership (expansion over time)
Shared resources (in kind/pro bono time, space, materials)
Range of stakeholder type
Parents included in meaningful way
Governance structure (regular meetings, defined roles)

Does the applicant/program meet the minimum criteria for innovation? ☐ Yes ☐ No

4. Evidence of innovation or creativity

1----------2----------3----------4----------5----------6----------7
Weak Acceptable Excellent

When evaluating the applicant's innovation, consider the following characteristics. Note: Different combinations of the following characteristics may lead to different ratings. Please also refer to these characteristics when providing feedback (either positive or constructive).

Flexible application of the program for the context
Unique implementation or adaptations made
Moving beyond programs to systems change
Local program development
Anything unique

Provide comments about applicant/program strengths:

Provide comments about applicant/program weaknesses, areas for improvement or issues for consultation:

Appendix III: School-Based Health Centers Improving Health Care Access & Student Success

NASBHC National Assembly on School-Based Health Care

Bringing Health Care To Schools For Student Success

School-Based Health Centers
Improving Health Care Access and Student Success

Research and evaluations have demonstrated that school-based health centers greatly enhance children's access to health care.

- Adolescents are 10-21 times more likely to come to a SBHC for mental health services that a community health center network or HMO. This data was confirmed in two separate studies. (2,3)
- 71% of students reported having a health care visit as compared to 59% of students who did not have access to a school-based health center. School-Based Health centers show significant increase in health care access by students who used SBHC's. These studies were multiple sites and were conducted by Mathematica Policy Research. (4)
- Decreased absenteeism and tardiness was widely reported amongst adolescents who received counseling services in a school-based health center. Those without centers reported slight increases in both absenteeism and tardiness. (1)
- Depressed and suicide prone students were much more willing to go to a SBHC for counseling than non reporting students. Overweight students and those with perceived weight problems were also more likely to use a school clinic for nutrition information. (5)
- 50% reduction in absences was attributed to medical services within the schools in Dallas school-based health centers among students who had three or more absences in a six-week period. Students who received mental health services had an 85% decline in school discipline referrals. (6)

Sources

1. Gall G, Pagano ME, Desmond MS, Perrin JM, Murphy JM. Utility of psychosocial screening at a SBHC. *J Sch Health.* 2000;70:292-298.

2. Juszczak L, Melinkovich P, Kaplan D, Use of health and mental health services by adolescents across multiple delivery sites. *J Adol Health 2003;32S:108-118.*

3. Kaplan DW, Calonge BN, Guernsey BP, Hanrahan, MB. Managed care and SBHCs. Use of health services. *Arch Pediatr Adolesc Med. 1998 Jan;152(1):25-33.*

4. Kisker EE, Brown RS, Do SBHCs improve adolescents' access to health care, health status, and risk-taking behavior? *J Adol Health 1996;18:335-343.*

5. Riggs S, Cheng T. Adolescents' willingness to use a SBHC in view of expressed health concerns. *J Adol Health. 1988 9: 208-213.*

6. Dallas Youth and Family Centers Program: Hall, LS (2001). *Final Report — Youth and Family Centers Program 2000–2001* (REIS01-172-2). Dallas Independent Schools District.

SBHC = school-based health center

NASBHC • 666 11th St., NW Suite 735, Washington, DC 20001 202-638-5872 • www.nasbhc.org

Appendix IV: National Contacts

Howard Adelman, Ph.D. Professor of Psychology & Co-director School Mental Health Project/Center for Mental Health in Schools Box 951563 Los Angeles, CA 90095-1563 Phone: (310) 825-1225 Email: adelman@psych.ucla.edu	Lisa J. Betz, LCSW, LCPC Mental Health and Schools Coordinator DMH- Child and Adolescent Service System 4200 Oak Park Ave. Chicago, IL 60634 Phone: (773) 794-4844 Email: Lisa.J.Betz@illinois.gov
Linda Anderson, MPH WV School Health Technical Assistance and Evaluation Center 159 Honeysuckle Lane Huntington, WV 25701 Phone: (304) 523-0043 Email: landerson@marshall.edu	Michele A. Carmichael Principal Consultant Illinois State Board of Education 100 North First Street Springfield, IL 62777-0001 Phone: (217) 782-5589 Email: mcarmich@isbe.net
Marc S. Atkins, Ph.D. Professor of Psychiatry and Psychology Institute for Juvenile Research (MC 747) 1747 W. Roosevelt Rd., Room 155 Chicago, IL 60608 Phone: (312) 413-1048 Email: atkins@uic.edu	Nic Dibble, LSSW, CISW Education Consultant School Social Work Services Department of Public Instruction PO Box 7841 Madison, WI 53707-7841 Phone: (608) 266-0963 Email: nic.dibble@dpi.wi.gov
Jessica Aufrichtig, MSW Behavioral Health Coordinator New Mexico Public Education Department 120 South Federal Place, Rm 206 Santa Fe, NM 87501 Phone: (505) 827-1803 Email: Jessica.Aufrichtig@state.nm.us	Lucille Eber Ed.D. Statewide Director IL PBIS Network 335 N. La Grange Rd Suite 4 La Grange Park, IL 60526 Phone: (708) 482-4860 Email: lucille.eber@pbisillinois.org
Susan Barrett Implementer Partner Center of PBIS 13625 Horselydown Lane Richmond, VA 23233 Phone: (804) 349-9648 Email: sbarrett@pbismaryland.org	Laura Hurwitz, LCSW Director, School Mental Health National Assembly on School-Based Health Care 1100 G St. NW, Ste 735 Washington, DC 20005 Phone: (202) 638-5872, x 205 Email: LHurwitz@nasbhc.org

Lauren Kazee, LMSW Mental Health Consultant MI Depart of Ed/Depart of Community Health 29538 Pickford Livonia, MI 48152 Phone: (517) 241-1400 Email: KazeeL@michigan.gov	Olga Acosta Price, Ph.D. Associate Research Professor Director, Center for Health & Health Care in Schools 2121 K Street, NW Suite 250 Washington, DC 20037 Phone: (202) 466-3396 Email: oaprice@gwu.edu
Joyce K. Sebian MS Ed. Senior Policy Associate National TA Center for Children's Mental Health 3300 Whitehaven St. Suite 3300 Washington, DC 20057 Phone: (202) 687-8245 Email: jks29@georgetown.edu	Kelly A. Stern State Educational Specialist School-Based Behavioral Health Program 641 18th Ave Honolulu, HI 96816 Phone: (808) 735-6225 Email: kelly_stern@notes.k12.hi.us
Sharon Hoover Stephan, Ph.D. Assistant Professor Center for School Mental Health 737 West Combad St, 426 Baltimore, MD 21201 Phone: (410) 706-0941 Email: Sstephan@psych.umaryland.edu	Linda Taylor, Ph.D. Co-Director Center for Mental Health in Schools UCLA Dept. of Psychology Box 941563 Los Angeles, CA 90095-1563 Phone: (310) 825-3634 Email: ltaylor@uclal.edu
Julie S. Owens, Ph.D. Associate Professor Ohio University Porter Hall 200 Athens, OH 45701 Phone: (740) 593-1074 Email: owensj@ohio.edu	Mark Weist, Ph.D. Department of Psychology University of South Carolina 1512 Pendleton ST Columbia, SC 29208 Phone: (803)777-8438 Email: weist@mailbox.sc.edu